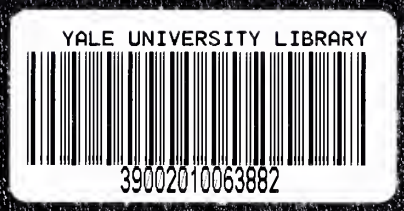

STOLE AND STETHOSCOPE:
A Survey of Physician Clergy Ordained in the Episcopal Church

Daniel Emerson Hall

Yale University

1999

Stole and Stethoscope:

A Survey of Physician Clergy Ordained in the Episcopal Church

A Thesis Submitted to the
Yale University School of Medicine
in partial Fulfillment of the Requirements for the
Degree of Doctor of Medicine

by

Daniel Emerson Hall
1999

WANTED, for a family who have bad health, a sober, steady person, in the capacity of doctor, surgeon, apothecary, and man-midwife: he must occasionally act in the capacity of butler, and dress hair and wigs: He will be required to read prayers occasionally, and a sermon every Sunday evening. The reason for this advertisement is, that the family cannot any longer afford the expences of the physical tribe, and wish to be at a certain expence. A good salary will be given. N.B. He will have liberty to turn a penny in any branch of his profession when not wanted in the family. (*Bath Chronicle*, Thursday, March 20 1777, reprinted in *Lancet* 2:985-986, Nov 15, 1952)

Yes, it is possible to integrate the two vocations of medicine and ordained ministry, " but it requires a willingness to share two worlds with colleagues who will not fully understand you. It requires a great acceptance of ambiguity. It is easy to get lost in activity and problem solving so prayer and some quiet are critical. It is a great life, but you can't take yourself too seriously."

--Anonymous Episcopal Physician Priest, 1996

ABSTRACT

STOLE AND STETHOSCOPE: A SURVEY OF PHYSICIAN CLERGY ORDAINED IN THE EPISCOPAL CHURCH.
Daniel Emerson Hall (Sponsored by Alan Mermann). Office of the Chaplain, Department of Pediatrics, Yale University, School of Medicine, New Haven, CT.

This study presents a comprehensive census and description of physicians ordained in the Episcopal Church. The names of 230 physician clergy (83 Episcopalians) were identified by mailing inquiries to all Episcopal bishops as well as the alumni officers of medical and divinity schools in the United States. Two thirds of the 83 Episcopal physician clergy responded to a five page questionnaire designed to gather demographic data as well as narrative responses to 26 open-ended questions about the relationship between the two vocations, medicine and ministry. Extended excerpts and analysis of the responses were documented.

The studied physician clergy were a diverse group of people who defied simple categorization. Together they represented every type of medical and clerical practice. Most had attempted to integrate their dual vocations, but this integration was often only informal. Very few had trained in both disciplines simultaneously. Instead, three quarters had started their careers in medicine, and one in five had begun in ministry. The second vocation was added an average of two decades after the first.

Overall there were two puzzling observations. First, these physician clergy struggled to articulate the theological foundations for their bivocational ministry. Second, there seemed to be little perceivable difference between the viewpoints and practice patterns of ordained and secular physicians. The author suggests two

explanations: First, the church currently lacks adequate language to describe or understand bivocational ministry, resulting in wide-spread confusion about the role of bivocation. Second, individual physician clergy have been isolated from each other, and therefore they have not had a community which could hold them accountable as they struggled to develop theologies and identities as bivocational clergy.

In the hope of initiating conversation, the author presents his own theological approach to bivocational ministry; in order to facilitate dialogue within a community of accountability, the author is constructing a list-server at:

www.members.tripod.com/~physicianclergy

ACKNOWLEDGMENTS

I would like to thank my faculty advisor, Dr. Alan Mermann for his consistent support, wise insight and kind patience. I am also grateful for the assistance and comments of Drs. David Katz, James Jekel, and Lauris Kaldjian. I particularly appreciated the suggestions and support of a fellow Episcopal physician cleric, The Rev. Dr. Robert Macauley. For moral support, I thank The Very Rev. Philip Turner. Elizabeth Hall, Ashley Beasley and Christopher Martin offered invaluable suggests during the preparation of the manuscript.

For financial support I am indebted to The Berkeley Divinity School at Yale and to the Office of Student Research at the Yale University School of Medicine. For departmental sponsorship, I thank the Department of Pediatrics.

Most of all, I thank all the people who responded to my surveys. This study would not have been possible without them. This includes the 82 diocesan bishops who returned my inquiry for names of physician clergy. It also includes the 137 alumni officers at divinity and medical schools across the country who searched their records for names of physician clergy. Finally, it includes the 52 physician clergy who gave freely of their time and spirit to share with me their thoughts about life in both medicine and ordained ministry. Thank you. I hope this study will start a conversation which will last a lifetime.

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INTRODUCTION

1. The Story

The inspiration and motivation for this study is inseparable from my own autobiography: Having completed a period of service in Zimbabwe as an Anglican missionary teacher of biology and chemistry, I returned to the United States with the plan of pursuing graduate education in both medicine and theology with the goal of becoming both an Episcopal priest and a physician. My intent was to approach the practice medicine as Christian ministry. Although not well-formed at the time, my intuition suggested that, in many ways, physicians function as the priests of our secular, materialist society. As the institutional church becomes increasingly marginal, and in a time when monastics and clergy are shedding clerical attire in favor of street clothes, it is curious to note that it is physicians who live in the cloistered environment of the hospital, endure elaborate initiation rituals, wear distinctive vestments, and preside over the major events of life from birth to death. I was not sure where my notion of bivocational ministry would lead, but I was intrigued by its potential.

After two years of intense study at the Yale Divinity School, I started my training in medicine. At that time, I had heard several anecdotal reports of other physician clergy across the country, but I had no idea how many physician clergy actually existed. I wanted to know who else was practicing bivocational ministry. I was looking for mentors who could help shape my career and guide my theological understanding of this unusual combination.

I attempted to locate a comprehensive list of physician clergy, but found only limited information. The Episcopal Church did not keep records on the "second" careers of their clergy. Neither the AMA library nor the National Center for Health Statistics had information about physician clergy. The Christian Medical and Dental Society had many

members who were faithful Christians, but they had no knowledge of any who were both physicians and ordained clergy.

A careful Medline search generated only three articles of interest. One was a biography of an Episcopal physician priest in Maryland.[1] The second was an obscure announcement of the 25th anniversary of an Australian society dedicated to bringing together the medical and clerical professions.[2] The third was a brief report of a 1984 survey of physician clergy in England.[3] In this study, surveys were mailed to 68 physician clergy in the United Kingdom. Forty-four surveys were returned describing a diverse group of people who defied categorization. However, of those 44, approximately half pursued both medicine and ministry concurrently whereas the other half had left one vocation for the other.

Having exhausted the existing resources, I resolved to develop my own study of physician clergy in the United States. My goals were simple, but broad. First, I wanted to know how many physician clergy existed, and to my surprise, I found more than 80 in the Episcopal Church alone. Second, I wanted to characterize this group of physician clergy to determine who they were, what they did, and how they thought. Finally, I wanted to develop a directory of physician clergy which might encourage and catalyze conversation between these unusual practitioners. The results of that census and survey are contained in this report.

2. Defining Terms

This study focused primarily on Episcopal physician clergy, and for the sake of clarity, there are several technical aspects of ordained ministry in the Episcopal Church which bear explanation. Within the Episcopal Church, the clergy are divided into three

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[1]Teter, C., "Leslie R. Miles, Jr., M.D.: Physician and Priest," *Maryland Medical Journal*, 1993, 42(11):1129-32.

[2]Storay, B., "Medico-Clerical Society of Victoria," *Medical Journal of Australia*, 1978; 2(13): 595.

[3]Leiper, Keith, "Medical Clergy: Square pegs in holy holes?" *British Medical Journal*, 1984; 289:1748-49.

orders of deacon, priest and bishop. Deacons "represent Christ and his church, particularly as a servant of those in need; and assist bishops and priests in the proclamation of the Gospel and the administration of the sacraments."[4] Deacons do not preside at the Holy Eucharist, and they do not bless or pronounce absolution. Their ministry is often considered one of service to and among the world. Their ministry is more often exercised outside the parochial environment, and they are under the direct supervision of the bishop. Deacons can be either "transitional" or "vocational." Transitional deacons are those ordained to the diaconate with the intention of later being ordained as a priest. (All priests must first be ordained deacon. All bishops must first be ordained priest). Vocational deacons are those deacons who have no intention of becoming priests. Although there are ancient roots for vocational deacons in history, this order dropped out of favor early in church history and has only recently been restored to its original integrity.

Priests "represent Christ and his church, particularly as pastor to the people; to share with the bishop in the overseeing of the church; to proclaim the Gospel; to administer the sacraments; and to bless and declare pardon in the name of God."[5] Priests are the most numerous of ordained clergy, and are most likely to be the ministers in charge of a parish.

Bishops "represent Christ and his church, particularly as apostle, chief priest, and pastor of the diocese; to guard the faith, unity and discipline of the whole church; to proclaim the Word of God; to act in Christ's name for the reconciliation of the world and the building up of the church; and to ordain others to continue Christ's ministry."[6] Bishops exercise their ministry within a geographical area known as a diocese, and they are the chief administrator and authority for the affairs of the church in that diocese.

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[4]*The Book of Common Prayer*, NY: The Church Hymnal Corporation, 1979, p. 856.
[5]*The Book of Common Prayer,* p. 856.
[6]*The Book of Common Prayer,* p. 855.

The ordination process within the Episcopal Church is unique for each diocese even though each clergy person is ordained for the entire church. The process includes theological training, but such education, in and of itself, does not qualify an aspirant for ordination. Each diocese administers its own process of screening and selecting candidates for ordination. This screening process typically requires more than five years and usually occurs while aspirants are completing their theological training. Under appropriate circumstances, the bishop may alter the process to accommodate the needs of a particular candidate for ordination.

3. Review of Literature.

The body of literature on physician clergy is quite small, and not all of it is published. In completing this study, an exhaustive Medline search was performed generating a total of 55 citations related in some way to physician clergy.[7] Of these citations, only a minority address the subject of physician clergy directly. Instead, most address issues of professional relations between physicians and clergy, or the interface between faith and medicine. However, what follows is as comprehensive a discussion as possible given the limited resources.

A review of physician clergy might best begin with anthropology. Levi-Strauss, Eliade and Turner have described how primitive cultures often have an identified person who functions as shaman, priest and medicine man. In his role as shaman/medicine man, this person presides over and interprets the mysteries of life and death.[8] Before the advent of modern, scientific medicine, the roles of priest, physician and philosopher were often similar, if not indistinguishable. However, in Western history, the professions of

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[7]A copy of the Medline search strategy is found in Appendix 2.

[8]For a more complete discussion, see Macauley, R., "Healing and Medicine: The common foundations of religion and medicine," 1995. This is an M.D. thesis available though the Medical Library at Yale University, New Haven, CT.

medicine and ordained ministry have always maintained separate, if often related, trajectories.

During the Middle Ages, universities were established primarily for the training of clergy. Consequently, formal education was most often limited to ordained clergy or professed monastics. Although only vestigial, the black academic regalia of the modern university continues to symbolize this intimate connection between the clergy and the university: Black clerical vestments and black academic robes share a common ancestry. Even though medicine was frequently learned outside the university through apprenticeship, there is no doubt that many of the practicing physicians of the Middle Ages were also clergy. Furthermore, hospitals as centers for the care of the infirm were first established by religious orders of the Roman Catholic Church.[9]

During the 17th century, the combination of medicine and ministry became more common. In England, the prevalence of physician clergy at this time was so great that they constituted a "dominant group in the medical profession."[10] This state of affairs developed out of the church politics of the time. With the rise of William Laud, the Nonconformist factions in the church were disenfranchised.[11] In this climate, young divinity students of Non-conformist persuasion could not find appointments in the church establishment. Anticipating the challenges for these Nonconformist clergy, "the universities incorporated the study of physic in the curriculum for the divinity student."[12]

Although ordained physicians were common in England during this time, they were not universally accepted. James Hart of Northampton published an extended

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[9]Cross, F. ed., *The Oxford Dictionary of the Christian Church*, New York: Oxford., 1990, p. 670.

[10]Harley, David, "James Hart of Northampton and the Calvinist Critique of Priest-Physicians: An unpublished polemic of the early 1620s," *Medical History*, 1998, 42(3): 362-86.

[11]Nonconformists were clergy who refused to conform to the doctrine and discipline of the Church of England. Also known as Puritans, they represented a wide range of Protestant sects. A series of Acts of Parliament known as the Clarendon Code established severe legal consequences for their nonconformity. See Moorman, J. R. H., *A History of the Church of England*, 3rd ed, Wilton CT: Morehouse, 1980, p. 252.

[12] Core, T.E., Jr., *History of American Pediatrics*, New York: Little Brown, 1979, p. 11.

theological critique explaining why clergymen should not profane their ministry by simultaneously practicing medicine. Hart suggested that the profession of medicine was too base and mean compared to the lofty call of ordained ministry. Hart developed several Biblical and theological arguments to show how God intended that ordained clergy should dedicate their energies exclusively to ministry.

In addition to this general history, there are several distinguished physician clergy who pursued both vocations. For instance, Niels Stensen (1638-1686), best known for discovering the duct of the parotid gland which bears his name, was both a physician and a priest. After distinguishing himself in both anatomy and geology, he converted from Lutheranism to Roman Catholicism, was ordained priest in 1675, and served as Vicar Apostolic of Hanover and then Bishop of Titiopolis where he published more than a dozen theological writings.[13]

At roughly the same time, Isaak Orobio de Castro was made famous by his theological disputes with Philipp van Limborch, Professor of Theology at the Seminary of the Remonstrants in Amsterdam. Orobio de Castro was a prominent physician and Marrano Jew who fled the Spanish Inquisition and continued his career in Amsterdam. In addition to practicing medicine, he was one of the leaders of the Jewish synagogue in Amsterdam, writing several unique theological tracts defending Judaism in a Christian environment.[14]

Over a century later, George Crabbe (1754-1832) trained first in medicine, but subsequently was ordained in the Church of England. He continued to dispense medical care to the indigent poor as well as write poetry. It is perhaps ironic that Crabbe was driven to the priesthood because it was too difficult to earn a living wage in medicine. During the 18th century, ordained ministry was one of the most secure professions; each

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[13]"Niels Stensen (1638-1868)--Physician, Geologist and Priest," *JAMA*, 1966; 195(2): 123-124.

[14]Ober, William, "Balthasar (Isaak) Orobio de Castro, M.D. (1620-1687): The Marrano physician and theological disputant," *New York State Journal of Medicine*, 1970; 70(11): 1321-28.

position was endowed with a comfortable "living." Crabbe used his living to subsidize his poetry and his medical care of the forgotten poor.[15]

In the early 18th century, the French physician M.F.R. Buisson joined forces with theologian Pierre Picot to argue against the Academie Française and the reigning opinions of anticlericalism and monistic materialism which suggested that faith and medicine were fundamentally incompatible.[16]

In the United States, the role of physician clergy can be traced to the first Pilgrims. Samuel Fuller (1580-1633) was the first physician in New England, arriving on the *Mayflower*.[17] He was also ordained. Later, Thomas Thacher (1620-1678) earned the respect and praise of Cotton Mather for his particularly "angelic conjunction" between the offices of minister and physician.[18] Although these early physician clergy did little to advance the cause of medicine, they "added another dimension to the minister's role in colonial life by easing pain, curing a sick child, and saving a life."[19]

Another example of distinguished American physician clergy is Aeneus Munson (1734-1826). After graduating from Yale College in 1753, he was ordained a Congregational minister and pastored a New Haven church for seven years. He then switched to the practice of medicine, earning renown for his encyclopedic knowledge of *materia medica* and botanical remedies. He became one of the most respected physicians in Connecticut, and in 1813, Munson joined three other eminent physicians in founding the Institution of Medicine at Yale College.[20]

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[15]Zaroff, Lawrence, "George Crabbe: Physician, Priest, Poet," *Journal of the Royal Society of Medicine*, 1997; 90(12): 697-701.

[16]Starobinski, Jean, "Le 'mediçin croyant' et le theologien genevois: Une lettre ecrite en 1802 par MFR Buisson a Pierre Picot," *Gesnerus*, 1991; 49 Pt 3-4: 333-42.

[17] Core, p. 11.

[18] Core, p. 12.

[19] Core, p. 13.

[20] Ives, Eli, ed., "Historical Sketch of the Medical Society of New Haven County," *Morning Journal and Courier*, New Haven, October 20-27, 1852 (as presented in an anonymous, unpublished summary.)

Only slightly later, Levi Rogers started his career as an ordained, circuit riding preacher of the Methodist Episcopal Church. He subsequently trained in medicine, setting up practice first in New Jersey and then in Ohio. In Ohio he followed an interest in law, becoming a prosecuting attorney and then state senator. He served as an Army surgeon during the War of 1812. Although medicine was his chief vocation, he did continue to preach and conduct marriages and funerals as needed on an occasional basis.[21]

Moving to this century, it is interesting to note that William Osler planned a career as an ordained minister. It was only after reading Sir Thomas Browne's (1605-1682) *Religio Medicini* ("A Doctor's Faith") that Osler was inspired to "see his study [of nature] as an important way of praising God." In fact, a copy of *Religio Medicini* was placed on Osler's bier during his funeral.[22] Active Christian faith remained an important facet of Osler's life throughout his career.

In the more contemporary period, there are several published anecdotes and biographies of physician clergy.[23] However, other than the 1984 study of physician clergy in the United Kingdom, there are no published systematic studies of physician clergy. The article with the broadest scope is a 1992 report in *American Medical News* based on interviews wth eight physician clergy of several Jewish and Christian denominations. In addition to the eight physician clergy interviewed, this article cited

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[21]Greene, P.F., "Levi Rogers: Frontier doctor, pastor and statesman, parts I, II and III" *Ohio State Medical Journal*, 1966; 66(2): 118-21; 62(3): 212-14; 62(4): 288-91.

[22]Martens, Peter, "The Faiths of Two Doctors: Thomas Browne and William Osler," *Perspectives in Biology and Medicine*, 1992; 36(1): 120-28.

[23]See Teter, 1993. See also Sheehan, M., "On Becoming Publicly Pro-Life," *America,* March 21, 1998, pp. 12-14; and Taylor, B. "The Rev. Leslie R. Miles, Jr., M.D.: The churchman as physician, the physician as priest," *Maryland State Medical Journal*, 1979; 28(11): 35-8. See also Teter, C., "Leslie R. Miles, Jr., M.D.: Physician and Priest," *Maryland Medical Journal*, 1993; 42(11):1129-32. See also Edward Cassum, S.J., M.D. in Nichole Berner Ahern, "Top Doctors," *Boston Magazine*, Feb 1999, p. 83.

unpublished reports that identified 20 Episcopal and 60 Roman Catholic physician clergy.[24]

Elizabeth Nestor is an Episcopal priest and Emergency Medicine physician who received a grant from the Smith-Kline Beckman Foundation in 1989 to research the topic of physician clergy when she was a medical student at Northwestern University. She estimated the nation-wide population of physician clergy of all denominations to be approximately 200.[25] She contacted 50 physician clergy and received completed questionnaires from 33. In general, Nestor found that physician clergy were "a very interesting group of people, but hard to classify, except for the obvious things, like they tend to be highly altruistic individuals."[26] Unfortunately, Nestor's work is unpublished, and I learned of it only at the end of my own survey.

The now dissolved Ministers in Medical Education Section of the Society for Health and Human Values published a 1979 directory of nearly eighty ordained clergy involved in healthcare education. Many were working to promote conversation between religion and medicine. However, none were both physicians and clergy.[27] Finally, the National Association of Self Supporting Ministry is a 30 year old society of bivocational clergy in the Episcopal Church. However, only a handful of members are physician clergy, and this group never published or maintained a list of physician clergy.[28]

Given the literature available, it is clear that the information gathered by this study is not available anywhere else. To the best of my knowledge, this report is the largest and most thorough census of physician clergy of all denominations. It is also the

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[24]Hearn, Wayne, "God's Messengers in the House of Medicine," *American Medical News*, May 18, 1992, pp. 43-54.

[25]Nestor, Elizabeth, "The Impact of Ordained Ministry on the Medical Profession," an unpublished report for a SmithKline Beckman Medical Perspectives Fellowship #SK30/88A, 1988.

[26]Hearn, 1992, p. 46.

[27]"Ministers in Medical Education: 79 styles of engagement in medical education as described by the men and women who created them," 5th ed., Society for Health and Human Values Ministers in Medical Education Section, 1979.

[28]This data reported during February, 1999 telephone conversations with NASSM founder Davis Fisher, and president, Ed Hook.

most comprehensive description of the thought and practice of Episcopal physician clergy.

4. Related Literature

Although there is very little literature directly addressing the subject of physician clergy, there are several articles which discuss the many ways in which physicians act in the role of priest or minister. What follows is not an exhaustive survey of this subject. Instead, it serves simply to acknowledge a related body of literature that explores the ways in which physicians occasionally function in the role of clergy. For example, Timothy Empkie points out, "people perceive a significant overlap in the roles of physicians...and clergy." He goes on to describe these roles as "listening, reflecting, guiding, comforting, asking the right questions more than having the right answers, showing compassion, and simply being available in times of stress and need."[29]

Along a similar line, J. Dominian describes three ways in which physicians function as prophets: speaking for God by establishing trust and hope, calling for repentance from unhealthy lifestyles, and prognosticating the future.[30] This prophetic role is frequently manifested by those physicians who preach the gospel of good health. As Samuel Vaisrub writes, "Often stereotyped and banal, yet not infrequently inspiring, the medical sermon is indispensable... The doctor does his share of preaching...on the evils of alcohol, tobacco, gluttony, and indolence...the gospel of work dedication."[31]

Others have commented that medicine and ministry share a common commitment to relieve suffering. William Bartholome suggests that the primary commitment of medicine to relieve pain and suffering "began as a moral or religious concept that found practical application in medicine...Medicine is part of health care, and health care is a

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[29]Empkie, T., "My Clergy, My Doctor," *Rhode Island Medicine*, 1993; 76(2): 83-5.
[30]Dominian, J., "Doctor as Prophet," *British Medical Journal*, 1983, 287:1925-27.
[31]Vaisrub, S., "To Practice and to Preach," *JAMA*, 1974, 227(5):555.

moral enterprise."[32] In another article, Judith Wilson Ross criticizes a recently proposed model of physician-patient relationship where the physician serves as a "priest who fills the spiritual vacuum we feel when, faced with serious illness, we discover our being-in-control cupboard is bare. This is the physician envisaged in the new emphasis on narrative, ethnography, and an ethics of caring."[33]

Although these examples explore ways in which the physician may act in the role of clergy, they do not address issues specific to ordained physicians. The issues and questions specific to ordained physicians are the subjects addressed by the remaining parts of this study.

[32]Hearn, 1992, pp. 43-54.

[33]Ross, JW., "Literature, Bioethics, and the Priestly Physician," *Hastings Center Report*, 1994, 24(3): 25-6.

STATEMENT OF PURPOSE

This study is designed to gather information about persons who are both physicians and ordained clergy. Specifically, it focuses on physician clergy in the Episcopal Church. It is a descriptive study intended to generate questions rather than test specific hypotheses.

The study has three parts. First, a comprehensive census of physician clergy throughout the country was conducted to discover the prevalence of this unusual combination of professions. Second, from this census, the Episcopal physician clergy were contacted and asked to complete a detailed questionnaire designed to characterize and describe this unique group of people: How old are they? Do they combine their two professions, and if so how? Did they pursue both professions concurrently, or did one precede the other? What types of medicine do they practice? What types of ordained ministry do they pursue? What motivated them to be both physicians and ordained clergy? How do their professions mutually influence each other?

Finally, the third part of the study looks toward the future. Although there are several hundred physician clergy in the United States, few of them know of each other's existence. A Web site, which will provide a forum for conversation between these physician clergy, is under construction. The Web site will also maintain a directory of physician clergy throughout the country. (See Appendix 4).

METHODS

PHASE 1- CONDUCTING A CENSUS.

After receiving approval from the Human Investigation Committee (HIC), letters were sent to various sources to generate names of physician clergy. During the spring of 1996, the author contacted: a) the 99 diocesan bishops of the Episcopal Church; b) the alumni officers of all 137 medical schools in the United States and Canada; and c) the alumni officers of the 139 seminaries with student bodies greater than 100 persons. The bishops were asked for the names of clergy in their diocese who had ever been to medical school. The alumni officers were asked to check their records for graduates who held advanced degrees in both medicine and theology. The response was encouraging with 83%(82) of bishops, 48%(65) of medical schools, and 51%(71) of divinity schools responding with information about physician clergy.

This first phase of the project generated a list of 83 physician clergy in the Episcopal Church. It also generated over 100 additional names of physician clergy in a wide range of Christian and Jewish denominations. Using basic techniques of extrapolation, the total census of physician clergy of all denominations in the United States was estimated to be close to 600.

PHASE 2- THE SURVEY

The second phase of the project sought to better characterize the patterns of practice found among the 83 Episcopal physician clergy. A five page questionnaire was developed in consultation with James Jekel and, subsequent to HIC approval, was mailed to the study group on July 20, 1996. 55 questionnaires were returned. This 68%

response rate is particularly impressive considering that the questionnaire required over an hour to complete.

The questionnaire had three parts, and can be found in Appendix 2. The first page requested biographical and demographic information from each person. The last page contained specific questions with multiple choice answers designed to test specific assumptions about this group of physician clergy. The remaining pages contained 26 open-ended questions designed to elicit detailed responses about theological and professional issues.

Phase 3--Data Analysis

Given the open-ended and narrative character of the data, analysis was difficult. Demographic data were easily coded into a spreadsheet. Likewise, the specific and mostly dichotomous data reported on the last page were also easily coded into a spreadsheet. It was more challenging to analyze the narrative responses to the 26 open-ended questions. The following system was employed: The entire set of questionnaires was reviewed multiple times by the author with the intent of noticing trends and common responses. For example, after reviewing all the surveys, there were four common responses to the question: "How, if at all, do you minister to colleagues and staff?" Those four responses were 1) yes; 2) no; 3) on occasion; 4) I never thought of it. A database was then constructed to code for these four possible responses. This system was applied to every question on the survey yielding a coding system and database for the entire questionnaire.

Next, each survey was reviewed question by question. In addition to coding specific responses into the database, representative responses were extracted verbatim or

in paraphrase. Finally, after reviewing all the responses to a single question, the author composed a subjective analysis of the responses, noting trends and patterns.

In some cases, the respondents attached additional pages to complete the questionnaire. Furthermore, not all the responses were directed to a specific question. Therefore, when coding the database, each complete survey was taken as a unit, and the respondent's opinions were recorded in the appropriate places even if those opinions were not recorded as a direct response to a particular question.

After completing all the coding, basic statistical tools were applied to the data. In some cases, the data pool was divided into subgroups, and comparisons were made. For example, priests and deacons did not always share the same responses. Retired persons often responded differently from those who continued to work.

Finally, all of this data was collected and recorded in a single document. This collected data is presented in the Results section of this study, and it is organized by survey question. After stating the survey question, the author provides a subjective analysis of the responses, followed by direct excerpts from the survey. For those interested in the raw database, it is presented in Appendix 1.

Limitations

This study is clearly limited by its method. Although every effort was made to preserve the integrity and objectivity of the data, the nature of the study required that each questionnaire pass through the interpretive lens of the author's mind. Even though many parts of the responses are presented verbatim, the structure and editing of those responses depend on the author's judgment. Therefore, the conclusions are intrinsically subjective, depending entirely on the author's observation and bias. As a result, the conclusions are not hard and fast. However, this subjective methodology is appropriate

to the primary goal of this study, which was to generate more questions which might be tested with greater rigor in future studies.

At its core, the subject of this study is sociology. Through 52 "interviews" conducted through a standardized questionnaire, the author sought to characterize an unique group of people who shared a common vocation to be both physicians and clergy. Such sociological research is "soft science" because the complexities of human communities and interactions do not easily conform to more rigorous scientific standards. However, valid conclusions do follow from rigorous sociological research. Sociologists have developed techniques of data analysis with their own integrity, and to the extent possible, those techniques were followed in this study.[34]

A further limitation of the study is the absence of an appropriate control group. The last page of the questionnaire tested specific assumptions about physician clergy, and it was intended that the last page of the survey instrument would be administered to a control group. However, the control was never completed because it proved too difficult to assemble an appropriately diverse cohort of physicians who resembled the study group of physician clergy, but were not ordained. This difficulty could be surmounted in the future with careful planning. However, for the scope of this current project, the results of the survey were compared not with a direct control, but with published statistics derived from samples representative of the nation wide population of physicians.

Finally, although basic statistics are presented about the study group, this report does not include any tests of significance. Given the limited sample size, and given the intrinsic subjectivity of the results, it would be misleading to report "p-values" because they might imply more statistical rigor than actually exists. The rigorous testing of hypotheses generated from this study remains a task for future research.

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[34]For further discussion, see Lofland, John, *Analyzing Social Settings: A guide to qualitative observation and analysis*, Belmont, CA : Wadsworth Publishing Co, 1984, pp. 1-186.

RESULTS

RESULTS, PART 1--THE CENSUS

A. BISHOPS

The names and addresses of all 99 diocesan bishops in the Episcopal Church were downloaded from the Internet.[35] In the spring of 1996, letters were sent to these bishops requesting the names and addresses of clergy in their dioceses who were also physicians. 83%(82) bishops responded generating a list of 74 names. Extrapolating these results to the entire sample, the estimated total census of Episcopal physician clergy is 89 (74/0.83).

B. MEDICAL SCHOOLS

The addresses of all 137 medical schools in the United States and Canada were obtained from the Internet.[36] Letters were sent to the alumni officer of each school requesting the names of their alumni who held advanced degrees in both medicine and divinity. 65 medical schools responded (48%) while only one letter was "returned to sender--address unknown." From these 65 responses, a list of 32 names was generated. However, these 32 names came from only 23%(15) of medical schools. Fully 37%(24) of the responding medical schools had inadequate records to answer the inquiry. The remaining 40%(26) kept adequate records, but none of their graduates held dual qualifications.

Extrapolating this information to the entire sample, it might be estimated that there are a total of 67(32/0.48) persons nationwide with dual qualifications. However,

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[35]Acknowledgment to Louie Crew, Box 30, Newark, NJ 07101. Email: 1crew@ondromeda.rutgers.edu. Path: http://neward.rutgers.edu/~1crew/bishops.

[36]See Path: www.aamc.org/meded/medschls/start.htm

this number does not account for those schools with inadequate records to respond to the inquiry. If the extrapolation uses only the 41 schools with adequate records, then it might be estimated that there are a total of 107(32/0.30) persons nationwide with dual qualifications. It is important to note that not all of these people are necessarily ordained. They simply hold graduate degrees in both medicine and divinity.

C. Divinity Schools

The addresses of all 139 divinity schools with ≥100 students were obtained from Peterson's guide to graduate programs.[37] Letters were sent to the alumni officer of each school requesting the names of their alumni who held advanced degrees in both divinity and medicine. 72 inquiries were returned for a response rate of 52%. A total list of 124 names was generated from 37 of these responses. There was a wide range of religious traditions represented by these 124 persons, to include Episcopalians (17), Presbyterians(32), Mennonites(7), Methodists(5), Roman Catholics(17), Reformed(2), Jews(4), and unspecified Christian (40).

Extrapolating these results to the entire sample, it might be estimated that there are 238(124/0.52) persons nationwide with dual qualifications. However, as with the medical schools, several schools [12(17%)] did not keep records adequate to respond to the inquiry. Therefore, if the extrapolation uses only the 60 schools with adequate records, then it might be estimated that there are a total of 288(124/0.43) persons nationwide with dual qualifications. It is important to note that not all of these people are necessarily ordained. They simply hold graduate degrees in both medicine and divinity.

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[37]*Graduate Programs in the Humanities, Arts and Social Sciences*, Princeton, NJ: Peterson's, 1996.

D. The Complete Census

The names from these three lists were cross-referenced to generate the total list of 83 physician clergy in the Episcopal Church. This study group represents a fairly comprehensive census, but additional Episcopal physician clergy have been identified subsequent to this study. It would be reasonable to estimate the total census of Episcopal physician clergy at approximately 100.

Within all other denominations, a list of 156 names was generated. There was no redundancy between the lists generated from the medical schools and the divinity schools. A reasonable estimate extrapolating these results would suggest a total of 350-400 persons with dual qualifications within other Protestant denominations. However, this survey did not adequately assess the Roman Catholic population. The Association of Sister, Brother and Priest Physicians is a support group for physicians who are also Roman Catholic nuns, lay brothers or clergy. In 1992, the group had 180 members of whom 60 were priests, and the remaining 120 were either nuns or lay brothers under monastic vows.[38]

Combining all these sources, it can be estimated that there are over 600 physician clergy or physician theologians in the United States at this time. The results are presented in the following chart.

Census Results for Physician Clergy

Source	*Total Names*	*Extrapolated Totals*
Bishops	74	89
Med Schools	32	107
Divinity Schools	124	288
Roman Catholic	---	180
Total	**230**	**664**

[38]Hearn, 1992, p. 44.

E. Denominational Representation

Not all denominations are equally represented in this sample. Bivocational ministry and training were more prevalent in specific denominational polities. There are two interesting explanations for this denominational disparity. First, bivocational ministry appears to be more common in traditions that call their clergy "priest" instead of "minister" or "pastor." The term "priest" does not imply a specific function, and therefore it may be easier to conceive of a "physician-priest." On the other hand, the terms "minister" and "pastor" refer to specific functions of the clergy, and given the fact that most physician clergy cannot be full-time "pastors," it may be more difficult to justify bivocational ministry within these denominations which define their clergy through their function.

The second explanation for the unequal denominational distribution of bivocational clergy roots itself in the cultural expectations specific to the American South. Earlier in this century, and persisting to this day, the only churches with "bivocational clergy" were churches not affluent enough to support a full-time minister. As churches grew in membership and affluence, it was important for those churches to relieve their pastors of any obligation to make their living outside parish ministry. A "tent making" minister was perceived as a sign that the church was unable to properly support its clergy. Because of this cultural stigma, there is a decreased prevalence of bivocational clergy in the American South, particularly in the Baptist tradition.[39]

[39]This explanation was described in a 2/2/99 telephone conversation with The Rev. Mr. Davis Fisher, founder of the National Association for Self-Supporting Ministries (NASSM).

RESULTS, PART 2--THE QUESTIONNAIRE

A. DEMOGRAPHICS

Eighty-three surveys were mailed to Episcopal physician clergy on 7/20/96. Two surveys were returned unopened by the postal service marked "return to sender--address unknown." Fifty-five completed surveys were returned making the response rate 68%. Of the 55 responses, 52 were physician clergy. The remaining three surveys were returned by clergy with Ph.D.'s in science. Although the responses recorded by these clergy scientists were interesting, they were not included in the analysis of physician clergy.

Of the 52 physician clergy, the average estimated age was 59±12 years (max 88, min 38).[40] They were 13%(7) women and 87%(45) men. They lived in every region of the United States, but fully 40%(21) lived in the "Bible Belt."[41] 76%(39) started their careers in medicine, adding ministry at a later date. 19%(10) started careers in ordained ministry, adding medicine at a later date. Only 5%(2) pursued training in both vocations simultaneously.

Concerning their vocation to ordained ministry, 64%(33) were priests, 30%(16) were deacons and 6%(3) were seminarians studying to be priests. 39%(20) attended Episcopal seminaries. 16%(8) attended non-Episcopal seminaries to include Lutheran, Roman Catholic, Reformed and Congregational traditions. Fully 45%(23) never attended

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[40]The age of each person was not ascertained directly. However, the dates of graduate degrees were recorded. To get a rough estimate of age, it was assumed that each person was 25 years old when they received their first graduate degree (M.D. or M.Div.). Their age was then calculated from their earliest graduate degree.

[41]For these purposes, the "Bible Belt" includes VA, WV, KY, TN, MO, AK, LA, TX, MI, LA, GA, FL, SC, NC.

seminary, obtaining theological training through officially sanctioned correspondence courses. During their careers, they had followed calls into almost every type of ministry, including service as rectors(23%), associates(48%), deacons(35%), chaplains(25%), missionaries(8%), spiritual directors(2%), supply clergy(17%), and "other"(15%).

Concerning their vocation to medicine, most were practicing physicians, representing nearly every type of medical specialty. Most attended medical schools in the United States, but several were trained in the Caribbean, South America or Europe. During their careers, they had practiced medicine in almost every setting, to include private practice(65%), clinical academic practice(37%), research academic practice(10%), group practice(33%), HMO/staff model(21%), administration(6%), medical missions(10%), US Armed Forces(4%), and "other"(8%).

On average, they had been practicing medicine for 33±13 years. Because most of the sample were ordained later in life, the average duration of ordained ministry was only 16±12 years. Regardless of which degree came first, there was an average of 19±11 years between completion of the medical and the divinity degrees.

B. Documenting the Data--Narrative Questions

As discussed previously, the nature of this study was qualitative and descriptive, and the questions of the survey were largely open-ended. There was a wide range in the depth and breadth with which study participants responded to the survey. The results of this study were consequently difficult to quantify. What follows is a summary of the responses given to each question in the survey. Each section begins with a statistical

summary of the data along with the author's assessment of notable trends. Following the summary are direct or paraphrased excerpts representative of the sample. Direct excerpts are in *"italic arial font"* and enclosed by quotation marks. Paraphrased excerpts are in [normal arial font] and enclosed by brackets.

The data are arranged by question in the order each question appeared on the survey instrument. It is important to keep the question in mind while reading the data, especially while reading the direct excerpts. For orientation, it may be helpful to first read the blank copy of the questionnaire found in Appendix 2.

1. Do you actively pursue both medicine and ordained ministry?

Of 52 respondents, 48 answered this question. Sixty percent (29) answered "yes" while 40%(19) answered "no". However, after reading the open-ended responses, it was clear that many who answered "no" had actively pursued both medicine and ministry at some time in the past. For example, several people were retired, and they no longer pursued either vocation. However, during their active lives, they had pursued both vocations simultaneously. Therefore, each questionnaire was coded to reflect its content, and according to this code, of the 52 respondents, 75%(39) had at some point in their lives actively practiced both medicine and ministry.

The survey was intended primarily for persons answering "yes" to this question. The majority of the remaining questions (#5-26) were directed to those who integrated their professions at least to the point of practicing both at the same time. However, those persons answering this question "no" were invited to answer two additional questions intended to help characterize their experience with both professions (#2-3).

2. Describe how you left one vocation for the other.

Of the 19 respondents answering "no" to question #1, 90%(17) responded to question #2. Of these 17, the majority [82%(14)] left medicine for ordained ministry, whereas only 18%(3) started as an ordained minister, leaving ministry for a career in medicine.

The reasons given for leaving one vocation for the other spanned every imaginable option. Each person had a unique story with a unique career path. However, the most common reason given for leaving a vocation was retirement [29%(5)]. Of the remaining persons, recurrent themes were: 1) a new sense of call; and 2) disillusionment with medicine, particularly regarding the time pressures which "prevent" spending time with patients.

Although they currently pursued only one vocation, 53%(9) explained that they had pursued both vocations at some point in the past. When asked if they thought it possible to integrate both vocations, four respondents supported the possibility of integration even though they themselves did not pursue both vocations. Only one person disapproved of integration. Another individual described how he had attempted to integrate both vocations, but failed, leaving medicine to pursue ministry.

> *"Effectively, I retired from the Navy and medicine at the time I entered seminary."*
>
> *"Many of my psychiatric patients were people in grief or crisis, and many were seeking both psychiatric and spiritual help/guidance. I felt I needed further training to deal more effectively with the spiritual--which I was becoming more interested in"* [This person practiced psychiatry for ten years before leaving medicine to pursue ministry as a priest.]
>
> [This pediatric orthopedic surgeon started in internal medicine, returned to graduate school for research, and then completed a residency in orthopedics. He subsequently earned an MBA, but did not enjoy medical administration. He served as the dean of a medical school, and is now retired to a ministry as a priest.]
>
> [This gentleman always felt called to ministry, but an aptitude test during WWII sent him into a career in medicine. He completed his residency, but immediately left medicine when the war was over and went to seminary. He served as a hospital chaplain for thirty years.]

> [After 32 years as an anesthesiologist, this man retired to the vocational diaconate where he works as a chaplain in an hospital using the *"same skills"* he used in anesthesia.][42]

> [This obstetrician had a late call to ministry after thirty years of medical practice. He did not go to seminary, but read for orders, and was ordained a vocational deacon. After two years of integrated practice, his experience with heart surgery convinced him to give up his medical practice and retire to chaplaincy work with the church.]

> [This radiation oncologist felt called to ordained ministry at an early age, but was unable to pursue that call until the late 1970s after the church approved the ordination of women. She was ordained priest in 1977, but moved to a diocese where women priests were not accepted. She therefore went back to school to study medicine. She does not consider herself to have left ministry, but she does not pursue it officially.]

> [This priest was ordained in the early 1950s and served in parochial ministry for several years before returning to school to become a psychiatrist. He was interested in the counseling aspects of parish ministry, and he wanted the formal training of psychiatry. He tried to integrate both vocations for some time, but eventually found the emotional and time constraints too challenging. He now practices psychiatry exclusively.]

3. How, if at all, does your previous vocation inform or influence your current work?

This question elicited a wide array of answers ranging from "no mutual influence" to a notion of influence that approached true integration. Of the 15 responses, 47%(7) stated that their previous vocation informed their current work in a positive and profound way. Thirty-three percent (5) acknowledged some positive, but minor influence. On the other hand, there was no mention of a negative influence from the previous vocation.

The most common form of influence was noted by former physicians who commented that their medical experience provided a broader and more intimate perspective on the human condition. They also found their medical background helpful when counseling sick parishioners.

> [This 38 year old priest eventually left medicine to pursue ministry. However, he does not see his two vocations as separate, and the influence of medicine is ever present.] *"I found it [leaving medicine for ministry] next to impossible to do. The nature of the questions assumes we are talking about two separate callings and*

[42]Presumably he does not mean putting these people to sleep during his sermons!

trying to weave them together. For myself, it has been a single calling that has taken on different focuses of expression at different times.

My calling is to a ministry of healing defined as a return to wholeness of body, mind, and spirit through reconciliation to God, self and others. I do not see either medicine or the priesthood as a job that I do; rather, they are arenas where God's calling on my life is played out. The danger in viewing doctor vs. clergy is that it attempts to place in worldly terms something that is in reality a "kingdom" issue. The usual job descriptions of priest and physician are influenced by a secular world mindset which leads to pigeonholing both as occupations with a preconceived list of behaviors. Through my country practice and an inner city pastorate, I'm learning that God's expectations routinely break through these assumed barriers. In fact, I believe that the friction comes between these two roles only when one attempts to define them separately."

"In hospital chaplaincy, I was greatly helped by [my] medical background: 1) comfort with patients and families and medical personnel and situations; 2) often interpreted physician's comments to patients and encouraged patients to relate better to physicians; 3) initiated [cancer patient] support team and ethical concerns committee; 4) gave broader view to illness and healing; 5) began first regular healing service in hospital chapel; 6) M.D. lent greater credibility to activity in healing ministry."

"A career in medicine provides a maturity in outlook. Previous life experiences allowed me to cope well in a very diverse mix of race, gender, age, and traditions on the campus."

"I can sometimes help with translation. I serve on the ethics committee at the hospital. Medical images occasionally show up in sermons."

"My knowledge of intra and inter personal dynamics is very helpful, as well as my experiences in individual group therapy--as I now work in pastoral care--utilizing times of crisis and transition for opportunities for spiritual growth---I no longer practice medicine per se, though I still have my license--I feel that the two are very integrated."

5. Describe how you were called to pursue both medicine and ordained ministry. How did you get to your current career situation? Could you have envisioned where you are now when you started training?

As the examples that follow will illustrate, each person's journey to bivocational ministry was unique. There were as many different paths as there were people, and the patterns of practice represented by this group reflect the complete range of career options in both medicine and ministry. For example, in medicine, there were psychiatrists, surgeons, family practitioners, cardiologists and anesthesiologists; and these physicians practiced in private, academic, HMO and missionary environments. In the church, there

were priests, deacons and seminarians who served as rectors, associates, deacons, chaplains and missionaries. None of the respondents stated that they could have envisioned where they were now when they started. One person wrote, *"If you really want to make God laugh, tell him about your plans."*

However, there were some common themes. The most common pattern was to start in medicine and add ordained ministry at some later time. This suggests that it is rare to pursue both vocations simultaneously. Of the 39 who pursued both medicine and ministry, 72%(28) started their career in medicine, 23%(9) started their career in ministry, and only 5%(2) started both vocations simultaneously..

Regardless of which vocation came first, there was, on average, an 18 year gap between ordination and graduation from medical school. This gap probably reflects the rigors of mastering one vocation before adding the challenges of a second vocation. Given that most physician priests started out in medicine, this gap is even less surprising considering the length of residency training and the demands of mastering the practice of medicine. However, although the average gap is 18 years, it ranges from 1-39 years with 18%(7) less than 6 years, and 31%(12) less than 10 years. This suggests that a significant portion of the sample was pursuing the second vocation before completely mastering the first.

The following page presents several charts which compare the demographic data of the studied group of physician clergy with lay physicians and Episcopal clergy.

Episcopal Physician Priests Who Pursue Both Medicine and Ministry[43]

N=39

DEMOGRAPHICS

	Episcopal Clergy (1994)	Physician Clergy	Physicians (1996)
Total Population	N=10,685	N=39	N=720,325
Age		60±12 (39-88)	49
Women	30%	13%(5)	21%
Men	70%	87%(34)	79%
Deacons	27%	36%(14)	---
Priests	72%	62%(24)	---
Seminarian	---	2%(1)	---
Retired	40%	28%(11)	---
Average Income	$45,434	$150,000	$199,000

MEDICAL SPECIALTY

	Physician Clergy	Physicians
Psychiatry	18%(7)	5.3%
Primary Care	38%(15)	33.5%
Internal Medicine	4	
Family Practice	7	
Pediatrics	4	
Specialists	18%(4)	10.6%
Cardiology	1	
Ped. Cardiology	1	
Radiology	1	
Anesthesiology	1	
Surgeons	26%(10)	14.1%
General Surgery	5	
OB/GYN	3	
ENT	1	
Ophthalmology	1	

MEDICAL PRACTICE

	Physician Clergy	Physicians
Private	18%(7)	28.0%
Academic (clinical)	21%(8)	1.3%
Academic (research)	0	2.0%
Group	5%(2)	30.0%
HMO	10%(4)	42.0%
Administration	5%(2)	2.3%
Mission	2%(1)	---
Other	10%(4)	13.0%
Retired	28%(11)	---

CHURCH SERVICE

	Physician Clergy	Episcopal Clergy
Rector	5%(2)	25.3%
Associate	31%(12)	8.5%
Deacon	33%(13)	16.2%
Chaplain	3%(1)	1.8%
Supply Clergy	7%(3)	2.5%
Other	10%(4)	5.7%
Mission	0	0.5%
Retired	10%(4)	40%

[43]Physician data from Gonzalez, M., et. al., eds., *Socioeconomic Characteristics of Medical Practice*, 1997/98, Chicago: AMA Center for Health Policy Research, 1998 and Randolph, L., *Physician Characteristics and Distribution in the US, 1996/97*, Chicago: AMA Center for Health Policy Research, 1997. Clergy data from conversation with Jose Malaret at the offices of The Church Pension Fund, 815 Second Avenue, New York, NY.

The call to a second vocation came in diverse ways, but there were five general patterns. First, many experienced a deepening of faith [23%(9)] or an adult conversion [5%(2)] which inspired the call to ordained ministry. Second, 15%(7) had always seen medicine as a form of lay ministry, but they eventually sought ordination because they were looking for something more complete and more formal. Of this group there were several who grew bored or disillusioned with parts of their medical practice which they were better able to address through their ordained ministry. Third, 13%(5) described an early call to ordained ministry, but practical reasons such as money or family pressure compelled them to pursue medicine. After some time in medicine, the original call to ordination returned. Fourth, 8%(3) started in ministry and were led to medicine through their experience as hospital chaplains. Finally, 13%(5) perceived both calls simultaneously, even if they were unable to pursue training in both vocations at the same time.

Although most responses fit one of these five general patterns, each person's experience was unique. The following excerpts exemplify the breadth and particularity of experience within this cohort of physician clergy.

> *"I had the audacity to point out that I was hearing more confessions as a physician a week than they* [the clergy] *were in a year."*
>
> *"The twin call to medicine and ordination were present since childhood. The call to medicine was better defined as I entered college--had no idea it could be possible to do both. Over the course of time I realized that simply practicing medicine was insufficient and less than totally satisfying. Friends and clergy encouraged me to look at the diaconate."*
>
> *"My calling was into medical mission Jan 17, 1956. Through prayer I heard that the best access to the true person (spiritual being) is through the mind and body in the intimate relationship I usually have in a [medical] office setting in a friendly encounter."*
>
> *"Already a physician, I had a deepening of my faith through Cursillo...which led to the vocational diaconate."*
>
> [After two years of residency this surgeon felt an *"awakening"* and given a local shortage of clergy, he "*looked into the priesthood.*" The bishop discouraged the idea of dual vocations until 25 years later when he was ordained to the vocational diaconate.]

[This person gradually changed the focus of his career. He started with surgery and moved to medical missions. This led him to seminary. He is now a priest who works in a parish as well as practicing general medicine half-time. He no longer performs surgery.]

[This physician first perceived a call to ordained ministry during college in the 1960s. However, at the time he felt uncomfortable with ordination, and he pursued medical training. Only recently has he acted on the call to ordination.] *"I have always felt medicine was a form of ministry. I have recently (5yrs) begun to feel the sacramental nature of daily practice--in some respects, I am completing a journey that began 30 years ago."*

[This physician was chair of pediatrics at his university when his parish called him to ordained ministry. He now practices a dynamic mix of academic and private medicine as well as ordained parish ministry, diocesan administration and administration of an Episcopal summer camp.]

[This physician was called to holy orders after starting psychiatric work with patients struggling with addiction.]

[This bilingual physician started his medical training in the Dominican Republic. In the last years of medical school, he heard the call to ordained ministry as a missionary. He studied missions in Quito, Equador. After his ordination, his parishioners convinced him not to abandon medicine. He now lives in the United States and works as a psychiatrist and as rector of a small bilingual church. He has a particular interest in the psychiatric and spiritual needs of cancer patients.]

[This physician always wanted to be a priest, but his father threatened to "cut him off" if he pursued ordination. Later in life, during his residency, he read for holy orders and was ordained priest. He now practices his own version of St. Paul's *"tent-making ministry."*]

"I am to serve my fellow man, and part of that calling was to seek the ordained ministry. A part of that ministry, I feel, ...is to help break down the current barriers between clergy and laity. Ministry is not an exclusive providence of either, but is given to all Christians by the charisma of our baptism."

[This physician was called first to medicine, but had a long-standing desire to study religion. He was eventually ordained under Canon 9 for service in a local community. Canon 9 is a special provision to ordain persons for ministry within a specific community. The ordination is not recognized outside that specific local community.]

[This person started seminary in 1952, but left to pursue medicine. Thirty years later, this physician rediscovered the call to ordination.]

[This woman had felt called to ordained ministry since high school. However, at the time, women were not ordained in the Episcopal Church. She therefore pursued a career in medicine. By the time she completed medical school, the church was ordaining women, and she entered the ordination process, enrolling in seminary.]

"Medicine is for me an expression of my ordained ministry." [While in high school, this physician felt called to be a priest, but he fell in love with science while at college. He subsequently earned his M.D. while reading for holy orders.]

"After ordination I felt called to write books on the soul...I had never thought of medical school prior to that."

"A priest is what I am, and medicine is what I do" [This person started his ministry as a full-time priest in England, but as a chaplain he *"became fascinated by the physiological/pathological circumstances"* of illness and pursued a career in medicine.]

[This priest entered seminary with no intention of pursuing medicine, but while completing his chaplaincy internship, he discovered a call to medicine.]

6. What is your theological foundation for pursuing these two vocations?

This question was intended to elicit a theological explanation for bivocational ministry. The notion of bivocational ministry remains confusing for many people both inside and outside the church. The dominant definition of ordained ministry is functional and parochial. That is, ordained ministry is defined by what ordained ministers do within the context of a church community: preach, lead worship, administer the sacraments, and provide the pastoral care for a community. Although bivocational clergy often do fill some of these traditional roles, their second vocations often dictate that the majority of their time is spent in traditionally secular, non-parochial roles. What then, is the justification for their ordination? Or in other words, what can ordained physicians do, by virtue of their ordination, that cannot be done by faithful, but not ordained Christian physicians?

This question exposes the heart of the confusion and controversy regarding bivocational ministry, and without an adequate answer the integrity of ordained ministry outside the parochial setting will remain suspect. It is well and good for faithful Christian physicians to pursue their medical practices for reasons of Christian service or a faithful response to God's call--But why must they be ordained to exercise that call? Why can they not follow God's call as lay physicians? Given that all of these physician clergy were actively engaged in bivocational ministry, it was expected that they would be articulate about the theological foundations supporting that bivocational ministry. They

were not and although there may be mitigating factors, this difficulty in articulating a theology of bivocational ministry will be a subject addressed at greater length in the Discussion section of this essay.

The difficulty respondents had with this question may suggest that the language was not clear. In fact, the better responses to the issues raised by this question were written in responses to other parts of the questionnaire. Another problem may be that the respondents considered the issue too complex for an adequate response in such a brief questionnaire. However, most people did compose a response, and the majority of those responses indicated that the respondents did not understand the essential tension in bivocational ministry. In fact, 12%(4) stated frankly that they did not have a theological foundation for pursuing both vocations. Furthermore, the general level of argument was not theologically sophisticated. For example, one stated his theological foundation was that there were *"many priests in [his] family."* Another stated that he *"felt called to a deeper ministry than that of an active layman,"* suggesting a confused theology that views ordination as a deeper, more advanced form of Christian commitment, but not in any way qualitatively different from lay ministry.

Theological sophistication is not essential for faithful ministry as either a physician or an ordained cleric. However, given the unusual and often controversial nature of bivocational ministry, it is surprising that the respondents did not display greater awareness and sophistication regarding this question. There may be several mitigating factors. First, it may be that physician clergy compartmentalize each vocation without any attempt to integrate the two. However, only 14% advocated this approach. The majority (86%) did in fact integrate the two vocations to some extent. Second, theological sophistication often fades after leaving seminary. Like a foreign language, the grammar of theology is lost without constant practice. For many reasons, the practice of rigorous theological reflection is often eclipsed by the practical necessities of life in the hospital or parish; many clergy grow rusty. Third, a large portion of this cohort of

physician clergy may not have ever been fully trained in theological argument. This conjecture is based on the observation that a remarkably high proportion of these physician clergy never attended traditional seminaries. Instead, 53%(21) "read for orders" through church-sanctioned correspondence courses. Although this reflects a laudable attempt to accommodate the needs of physicians seeking theological training, it may partially explain the lack of sophistication.

Theological Education of Physician Clergy

	Episcopal Seminary	Non-Episcopal Seminary	Read for Orders
Total(N=39)	13	5	21
Priest(N=25)	11	5	9
Deacon(N=14)	2	0	12

Regardless of the mitigating factors, the lack of sophistication remains troubling. Patients expect sophistication from physicians when considering the choice of medication, surgical procedure or diagnostic test. Both the church and the hospital should expect similar sophistication regarding the justification for bivocational ministry.[44]

Turning to the actual responses to this question, a common approach rooted the foundation for bivocational ministry in personal experience. Many physician clergy simply stated that the reason they pursued both vocations was that God "called" them to both. Beyond this assertion of an experience of God's call, they did not share any further reflection on the theological reasons for pursuing both vocations. This argument frequently appealed to St. Paul's metaphor of the church as the body of Christ: Just as the body is made of different parts, so the church is made of different people with different roles. Some are called to be prophets, teachers or parents. These physician clergy felt called to be priests and physicians.[45]

[44]For a more extensive discussion, see the following Discussion section.

[45]For St. Paul's metaphor of the body, see the first letter to the Corinthians, chapter 12.

Thirty-six percent (13) explained that medical practice was simply the most appropriate way for that individual to live out a life of Christian service:

> *"Jesus calls us to preach, teach, and heal. What better way than combined medical-clerical practice."*
>
> *"Everything I have is gift and needs to be used in service (diaconia) of others."*[deacon]
>
> *"Deacons are called to a ministry to the sick , the hurt, etc. This is what I do as a physician as well."*[deacon]

This response was most common among deacons, and as such, it constitutes a theologically sound argument because deacons are ordained to a lifetime of service-oriented ministry outside the parochial setting. Consequently, there is less controversy regarding bivocational deacons. However, several priests (7) offered this type of argument as justification for their bivocational ministry, but they failed to describe how such a life of Christian service was made unique by ordination.

Another common response [24%(8)] appealed to a holistic approach to medicine that treats both body and soul: *"The Holy, the soul and the body are a unity, inseparable--a non-dualistic theology."* Some argued that medicine was simply a broader arena for the practice of ordained ministry: *"Making Christ known in the world and putting new dimensions on my practice."* Others pointed to the need for "tent-making" clergy who could support themselves by secular means. Other notable and unique responses follow, but again, none offered an explanation of how their ministry was made unique by ordination.

> *"The Holy Spirit will lead you into all truth, combined with my 8th grade motto: "may we always be willing to give up who and what we are for what we may become" coupled with Paul's [ideal of becoming all things to all people]."* [priest]
>
> *"The soul is treated by psychiatrists, but incompletely."*[priest]

Several made arguments that effectively broke down the distinctions between clergy and laity, but again, they did not adequately explain why, if there is no distinction, they found it necessary to be ordained.

> *"I have only one vocation and that is to be Christian. The church continues to talk about bivocational priests and/or clergy to which I take exception. We all have one*

> *vocation...it can be expressed in multiple ways. It is expressed in my life as a doctor, priest, father, husband, friend. I do think that the discussion should be about the difference between non-stipendiary or non dependent clergy and the stipendiary clergy. The covenants or contracts between the parish [and these two types of clergy] are different. Both are ways of participating in God's activity of loving and healing this broken world."*[priest]

> *"[The theological foundation is the] baptism of all believers. Next part is a further vocation within community to preach, build up, teach gospel and Eucharist."*[priest]

Despite the problematic character of many responses to this question, several were thoughtful and profound, recognizing the tension implicit in a functional definition of ordination. Several respondents resolved this tension by rejecting the functional definition in favor of an ontological notion of ordination: *"A priest is what I am, and medicine is what I do."* However, nobody articulated a complete theology supporting bivocational ministry.

7. Do you integrate both vocations into a unified whole, or do you keep both vocations separate? Please describe how and why you integrate or separate medicine and ordained ministry.

Thirty-six people responded to this question, and again, the range of responses was vast. However, most fit one of four patterns even if the motivations behind each pattern were different. First, 14%(5) deliberately separated the two vocations, completely segregating the roles of physician and priest. However, the motivations for role segregation varied. Some worried that any attempt to integrate roles might confuse themselves or their patients about which role they were playing at a given moment. Others pursued medicine exclusively as a "tent-making" profession which supported their ordained ministry. Still others gave no reason for role segregation other than personal preference or habit.

> *"I kept them fairly separate--compartmentalized the medicine (a.m. medicine, p.m./weekend ministry)"*

> *"Blending them too closely invites confusion."* [This physician priest often used the metaphor of "different hats" to separate his two roles. He thought it essential not to confuse the different roles. For example, he never wore his clerical collar to the

hospital, and he never assumed responsibility for the medical care of his parishioners.]

"I have never been able to integrate both vocations. As I reflect on both educational events, I find both were quite different in approach. Please remember my medical education occurred in the mid fifties. Medicine at that time, I think, followed a paternalistic and patronizing model: "I know what is best for you and don't ask questions." This may be a simplistic statement, but I believe it to be fairly accurate.

In the hierarchical system of medicine, medical students were demeaned at every turn. Self confidence and self acceptance were alien terms. This teaching continued through internship and early residency. In my later residency I began to develop some self assurance

When I went to seminary, I found the teaching model to be that of engaging, supportive and self empowering.

Attempts were made to integrate both vocations both by myself and the faculty and my bishop. Over the years I still remain a bit schizoid. I have not found a lot of support from either the medical or clerical communities."

The second group expressed some notion of internal integration, but they never made it public[17%(6)]. Their public roles were segregated, but they integrated their sense of vocation within their own hearts and minds.

"Yes, in my heart, but [it is] difficult to practice medicine [and to be a priest as] completely as I would want."

"Practically, it is not feasible to do the two together." [This person does not formally integrate the two professions in a public way. However, other responses show that he does integrate his two vocations at least within his own heart and mind.]

"They are inseparable for me." [But only internally, not publicly]

The third group partially integrated the two vocations to varying degrees according to context[25%(9)]. They recognized several potential pitfalls or conflicts of interest involved in merging the two vocations. Others acknowledged that, depending on the context, one vocation takes precedent over the other. Several people commented that external forces make it appear easier and more comfortable to segregate the roles, and many people described their initial fears about integrating. Consequently, they initially segregated their roles. However, over their careers, they increasingly integrated their vocations, and in hindsight, some expressed regret for not integrating earlier and more completely. Most of the difficulty regarding integration, said one person, was his own fear and *"hang-ups."*

"Where possible I integrate, but early on I separated to avoid confrontation and develop friendships---but I would try to work in an environment that left a lot of clues to my intention of practice."

"I see medical practice as a diaconal ministry. Initially I kept actual practice of medicine totally separate, and still feel evangelism must be avoided in the clinic because it can abuse the power entrusted to physicians."

[This person did integrate the two professions, but he integrated only with great care, tailoring his approach to the individual context. He found the process of integration challenging because] *"Malpractice and good intention seem to go hand in hand."*

"In CPE [Clinical Pastoral Education] I had to learn to back off from the clinician role...I learned to come to the left side of the bed."

""One person living one life"--unified--however one may predominate from time to time."

"integration is inevitable"

"increasingly integrate"

The fourth and largest group integrated both vocations so completely that several individuals were offended and frustrated by the question[44%(16)]. They could not see any division. Although each vocation had distinct roles, at the heart of the matter, it was one calling, one vocation, one set of gifts woven into a unified whole.

"They are two seams of the same fabric. The separation of faith from science is part of our problem in health care today."

"I see both vocations as a unified whole. I provide pediatric care for virtually all the children and youth in our congregation. And, having baptized most of them, prepared many of them for confirmation, and for several have officiated at their weddings, I believe I have provided care for their spiritual and sacramental lives as well."

I am constantly integrating my diaconal vocation in my practice--faith issues, pastoral care, prayer....There is relief from them [patients] that they can discuss faith issues.

"My ministry as a Christian overrides both careers and brings them together in a blending."

"It would seem schizophrenic to separate the two. (I am a third order Franciscan, and that helps to integrate work, prayer, studies)."

"Integrate healing into practice of holistic care. Stay alert to indications of desire for theological/spiritual help."

"Integrate--One of the difficulties facing the church is the almost schizoid relationship that we try to maintain with the church on the one hand and the world on the other."

8. How does medicine inform your practice of ordained ministry?

This question did not inspire lengthy responses, although 82%(32) actually answered the question. Many did not find it interesting, warranting only a couple of words. Perhaps they had already addressed the issue in previous questions. However, several offered extensive, elaborate and fascinating discussions.

Of those who responded, there were five categories of answers. The largest category [53%(17)] explained how medicine fostered an open mind not always found in parochial clergy. Experience in medicine also broadened their perspective, giving them greater insight into lay people, the human condition and human suffering.[46] It was also noted that medicine afforded greater access to people, particularly the "unchurched."

The second category [16%(5)] included responses expressing some version of natural theology where the scientific understanding of the human body informed the theological understanding of the world and of God. The third category [9%(3)] suggested that medicine gave people a more accurate knowledge of human limits. A fourth category [13%(4)] included people who found no influence of medicine on their ministry, and they thought it should stay that way. They preferred to isolate the roles. Finally, a small group did not understand the question [9%(3)].

> *"Gives me broad experience in the realities of every day life, joy and pain."*
>
> *"I appreciate life and health more and it focuses my preaching."*
>
> *"More open mind, but it can tend toward cynicism."*
>
> *"Sermons have different insights and wider experience base than monovocational priests."*
>
> *"Insight from practice helps "inform the church of the needs of the world.""*
>
> *"A medical viewpoint often colors theology and people do bring that up."*

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[46]For an historical example of this accentuated sensitivity to human suffering, see the discussion of the poetry of 18th century physician priest, Jonathan Crabbe in Zaroff, Lawrence, "George Crabbe: Physician, Priest, Poet," *Journal of the Royal Society of Medicine*, 1997; 90:297-701.

"Having an intimate knowledge of the created human body helps me to better interpret the works of the spirit in my life and the lives of my patients."

"not much"

"Perhaps in supplying a substrate of pain and chaos to offer up to God and my congregation."

"Medicine makes me more acutely aware of my own inadequacy and fragility...very aware of human limits."

9. How does ordained ministry inform your practice of medicine?

The 31 responses to this question were similar to question #8 in range, brevity and interest. Again, 10%(3) suggested that there was no mutual influence, and the roles should remain segregated. Another 10%(3) misunderstood the question. Another small group suggested that ministry made them more aware of human limits [7%(2)]. However, the remaining respondents shared essentially two answers. The majority [65%(20)] suggested that their ordained ministry improved their care of the whole patient, equipping them with greater awareness and skill in dealing with spiritual and emotional issues. The remaining 10%(3) suggested that their ministry informed their ability to deal with difficult ethical issues, particularly concerning the end of life.

"Constantly reminding me of the difference between curing and healing....that the medical model alone is lacking."

"A pastoral care model in treating patients shapes my approach to patients--faith basis to walk with people through pain/tragedy keeps me grounded in my call to imitate Christ ."

"Reminding me to be totally present to the other, to the one in need."

"All persons are possible places where the Christ, in his suffering and wounded presence, is among us."

Helps answer the question "why did baby die, wife die, wife develop cancer, etc."

"Theological critique of scientific hegemony."

"The Lord heals and the doctor takes the fee."

10. If you could pursue only one vocation, which would it be? Medicine or ordained ministry--why?

Of the 33 responses to this question, 42%(14) chose medicine, 27%(9) chose ministry, and 30%(10) refused to choose, stating that the choice was impossible and a *"false dichotomy."* On further analysis, 22 explained their choice with one of four basic reasons. The largest group [42%(10)] explained that the chosen vocation was their core identity. Seventeen percent (4) chose medicine for financial reasons. Another 17%(4) chose the vocation in which they first trained because it was the first and most formative. Finally, 17%(4) chose one vocation over the other because they were better at it.

> *"If I could retire, I'd do so in a minute and do more diaconate work."*
>
> *"A good doctor can be a good deacon too--the reverse is not true."*
>
> *"Medicine pays five to ten times more so it is difficult to justify ministry financially, given a shortage of time."*
>
> *"[Medicine affords] more intimate opportunities with little suspicion from people in general--but men in particular."* [For this reason, he chose medicine.]
>
> *"I wouldn't want to choose...it would leave a huge hole if I gave up one."*
>
> *"Too old to continue OBGyn."* [This physician was retired]
>
> *"The ordained ministry constitutes a deep and irreversible relationship with Christ. Medicine is a big part of who I am, but not like ordination."*
>
> *"Ordained ministry is more life giving to me than medicine."*
>
> *"Ordained ministry is the highest calling."*
>
> *"Ministry gives me more of an opportunity for working with the whole person When I was a psychiatrist, and especially a teacher of medical students and residents, there were restrictions regarding sharing of faith, prayer, and personal spirituality."* [This priest chose to leave medicine for full-time ordained ministry.]

11. What do you offer that is not offered by lay physicians or monovocational clergy?

This is another question intended to elicit reasons for pursuing bivocational ministry. Is bivocational ministry greater than the sum of its two parts? The content, variety and sophistication of responses were similar to question *#6 "What is your theological foundation for pursuing these two vocations?"* Some of the comments were repetitive.

Of the 32 responses to this question, it was surprising that 13%(4) wrote that they offered "nothing" unique. This response makes sense coming from those persons who chose not to integrate the two professions, segregating their different roles. However, several people explained their response of "nothing" by appealing to a surprising theology of ordination that minimized the differences between lay and ordained Christians, appealing to an unusual interpretation of the "priesthood of all believers."

The most interesting responses explained how through their bivocation, they functioned as "translators" between the two worlds of medicine and ministry. Alternatively, there were more predictable themes such as financial independence, fresh perspective from the pulpit, sacramental absolution [6%(2)], greater breadth of experience [25%(8)], and a greater attention to spirituality and suffering [38%(12)].

> *"Medicine...brings me people who have not been in church for years--many would not seek help from clergy."*
>
> *"A deeper understanding of [the] medicine/faith interface. I often feel as if I act as a "translator" of one language into the domain of the other."*
>
> *"Bringing together [the] scientific and spiritual...Being a family doctor is a lot like being a parish priest."*
>
> *"I feel that lay people can identify more readily with a vocational deacon--deacons somehow bridge the gap between lay and priest."*
>
> *"I represent a person who understands more of the peculiar demands of their [parishioner's] life and relationships...However, many clergy seem intimidated."*
>
> *"I think my perspective on questions of life and suffering are deepened by my priestly absorption in the scriptures and liturgy."*

"[I have a greater] capacity to address and cope with end of life issues...If you believe that death is not the worst thing that can happen to a person, you are free to serve in a special way."

"I think I have a slight edge on monovocational clergy in my ability to understand and reckon with human suffering."

"Not being dependent on church whims/money for financial support."

"I pray for patients and ask for God's healing grace, although my patient might not know that I do so."

"In my experience, I hear more about the patient's sex life, smoking, alcohol problems, and drug usage as a doctor/priest than I did before ordination."

"I hope and pray that I can be an example of the integration and wholeness of life offered in the ministry of our Lord Jesus Christ."

"balance"

"As a deacon, I can bridge the needs of the world with the...laying on of hands in the name of Jesus Christ."

12. Do you let patients know that you are ordained? If so, how? What is the reaction?

Eighty-seven percent (34) responded to this question, and unlike some other parts of the questionnaire, there was no confusion. As expected, the range of answers spanned all possibilities from "never" to "always." The majority [59%(20)] explained that they did not routinely inform their patients about their ordination, but when asked or when under "appropriate" circumstances, they freely shared the information. Approximately equal numbers of people shared the information all the time [12%(4)], or never [15%(5)]. 6%(2) described planting clues to their ordination such as a crucifix or an ordination certificate. Several others took a more direct approach and frequently wore clerical collars in medical settings [9%(3)].

Although there was one mention of an adverse reaction from a patient ("Am I dying?"), most people described only positive reactions from patients who were relieved, joyful, or grateful.

"Absolutely. At first I was hesitant to do that, but I've never had anyone react other than in a positive, supportive and grateful manner. Clearly my reluctance to let people know at first was based upon unfounded fear and anxiety."

"Yes...if I think it would not cause them confusion."

"When I feel it would be helpful...useful when authority of the church is needed."

"No. A few patients have known I'm a priest and are uneasy, even frightened: "Am I dying?"

"Not routinely. I generally discourage parishioners from becoming patients and vice versa--too hard to keep hats separate."

[In an extended response, this person argued that showing "*love and compassion*" was more important than "*knowing my titles.*"]

"At times I still have clericals on."

"I commonly wear a round clergy collar to work (and I live in a small enough town that everyone knows)."

"Reaction of appreciation and interest."

"Reactions differ from surprise to wonder to indifference."

"Most [patients] have said, 'I thought you were different than the others.'"

13. How do you view the patient-doctor encounter? What is appropriate? What is not appropriate? Is evangelism appropriate? Do you ever act as priest and physician to the same person? How do you manage the power issues of being both a doctor and a priest?

In hindsight, this was a poorly designed question. It was too large, complex and overwhelming. Many people did not engage with the question, or included only brief, one word answers. However, the issues raised by this question were frequently addressed by the respondents in other parts of the survey. Taken as a whole, there were several interesting trends.

Regarding the patient-doctor encounter and the propriety of certain behavior, this group of physician clergy adopted a largely uncritical version of the medical model of the patient-doctor relationship. Consistent with the older age and earlier medical training of the group, the dominant model of relationship was more traditional with a paternalistic, "doctor-knows-best" approach. The respondents were largely silent about the more

recent critiques of the patient-physician relationship which encourage more open-ended questions and non-directive listening techniques designed to allow the patient to guide and shape the encounter. However, despite this generally traditional approach, there were several respondents who spoke with sensitive sophistication about the newer approaches to the patient-physician encounter.

> *"The physician/patient relationship is a partnership depending on trust. Anything, attitude or action, that could violate that trust is not appropriate. Introducing the Christian view of life may well be appropriate...never forced or aggressive."*
>
> *"I have found over the years that, sadly, my medical colleagues have a much better sense of appropriateness [than clergy]." [In context, he is referring to the misconduct of clergy, sexual and otherwise.]*
>
> *"Anything that violates the patient's autonomy is inappropriate because of the inherent inequality of the patient-doctor relationship. Evangelism isn't appropriate."*

Consistent with their more paternalistic approach to the patient-physician relationship, many of these physician-clergy glossed over the question about power issues, stating that the power issues were not a problem because as physicians they always acted in the best interest of their patients, never abusing their power. Several people commented that they never recognized the existence of power issues. One person accused the question of advancing a "politically correct" agenda. Others simply passed over the obvious power issues by claiming that clergy did not really hold any power. For example, one deacon suggested that only the priests have power, and as servants, deacons did not need to concern themselves with power issues: *"There is a power issue in being either a physician or priest. A deacon is a servant, which is easier to integrate with medicine."* Although there were several sophisticated responses, it is troubling that so few respondents demonstrated awareness or insight about the complex power dynamics of being both priest and physician.

However, to their credit, the respondents were exquisitely sensitive to the power dynamics involved in evangelism. Many took care to distance themselves from any type

of coercion or proselytism while others wrote sensitive explanations of how and why they evangelize.

> *"I'm not certain that there is a place for evangelism in the consulting room. However, if [evangelism is] simply letting a patient know that you are an ordained minister, and that you are open to a spiritual consultation as well, then I have engaged in evangelism."*
>
> *"Evangelism-on occasion, yes...gently, not forcefully."*
>
> *"Yes--evangelism is appropriate."*
>
> *"Evangelism is not in what is said, but how we act."*
>
> *"Love evangelizes--what I have are the "tools" and methods of love through medicine and sacrament. [They] are not mutually exclusive."*
>
> *"I doubt that evangelism, per se, is appropriate for a vulnerable, ill patient...at the same time I occasionally offer prayer or sacraments...I often ask if they know or want to know about Jesus Christ."*

Despite these sensitive comments, many people suggested that evangelism of any kind should be avoided at all times. Without doubt, the concept of evangelism has been marred by abuses of the past as well as the excesses of modern Televangelists. However, evangelism is an essential doctrine of Christianity.[47] Furthermore, during their baptism and ordination, each of these clergy vowed to "proclaim by word and example the Good News of God in Christ".[48] Properly understood, true evangelism contains no element of coercion or manipulation. It is sad that so many of these clergy were unwilling or unable to redeem the notion of evangelism for a more proper understanding.

> *"I don't proselytize."*
>
> *"Evangelism violates the social contract. Inquiry into and support of faith is good."*
>
> *"avoid manipulation."*

Finally, there was a predictably wide range of response to the question about acting as priest and physician to the same person. The responses roughly corresponded to the answers to the earlier questions regarding the integration of the two professions. As

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[47]The Gospel of Matthew concludes, "Go therefore and make disciples of all nations, baptizing them in the name of the Father and of the Son and of the Holy Spirit"(Mt. 28:19 NRSV).

[48]*The Book of Common Prayer*, p. 305.

would be expected, those physician clergy who segregated their roles as priest and physician never acted in both roles to the same person. Likewise, those who completely integrated their two vocations always offered to act as both priest and physician. However, the general consensus was that although the dual roles could be appropriate at times, it could be confusing for both the patient and the physician. Some of the more integrated physician clergy suggested that the boundary issues were easier to negotiate if both roles were openly revealed and discussed. In any case, all agreed that the combination of both roles must be done with great care.

> *"I usually separate the two roles."*
>
> *"Of course [I act as priest and physician to the same person. However], when I went to St. Luke's as a chaplain, the medical staff asked for some assurance that I would not relate as an M.D. to their patients."*
>
> *"Deacon/physician to same person--very tricky."*
>
> *"Yes, I do act as priest and physician to the same person."*

14. How, if at all, do you introduce God into the patient-doctor encounter? Do you have a standard way of introducing the subject of spiritual issues to the patient?

Of the 35 who responded to this question, the most common approach was to introduce spiritual issues only when "appropriate" or when directly asked [69%(24)]. Although this group did occasionally participate in spiritual discussions during a patient encounter, the consensus was that such encounters were rare. For many, raising spiritual issues was perilously close to "evangelism." As in the question regarding integration, there were roughly equal minorities of people who either always [9%(3)] or never [11%(4)] included spiritual issues. As in the case of letting people know about their ordination, a small group [11%(4)] planted gentle hints during patient interviews such as *"offering to keep it in prayer."* These hints gave permission for the patient to initiate a

conversation. It is perhaps interesting to note that those who most directly introduced the subject frequently lived in the "Bible Belt."

> *"If appropriate, I will mention options for pastoral counseling."*
>
> *"On those occasions when appropriate--for example a person facing severe or life threatening disease."*
>
> *"My parishioners are patients of mine, and some of my patients have ended up coming to my church."*
>
> *"When this is appropriate it usually comes about by my own willingness to express my own limitations and dependence on God to bless my efforts."*
>
> *"I ask about spiritual supports as part of [my] social history."*
>
> *"Weep with those who weep, laugh with those who laugh. I often ask if they know or want to know about Jesus Christ."*[Bible Belt.]
>
> *I ask the person if they believe in God and if they say no, I make a mental note of that and pray for them silently then, and wait for a more opportune time or situation. If they say yes ...we talk about where they are in their pilgrimage especially if they say they are Christian."*[Bible Belt.]

It was obvious that these physician clergy were attuned to spiritual issues in the patient encounter, and although they sometimes had reservations, they were generally willing to address spiritual issues in the appropriate context. However, very few had systematized their approach to initiating spiritual discussions. Most appealed to some form of a vague open-ended question such as *"Is there anything else in your life which you feel may have some bearing on your condition."* Only 9%(3) included a spiritual history as part of their routine patient encounter. However, a national poll suggests that 82% of patients want to discuss spiritual matters, and 64% want their physicians to pray with them.[49] Given this evidence, it is surprising that so few of these physician clergy are not more deliberate in raising spiritual issues.

It is not clear why these physician clergy are reluctant to address spiritual issues directly. However, in their reluctance, they follow the national trend for all physicians.

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[49]Wallis, C., "Faith and Healing," *Time*, June 24, 1996: 62. See also King, D.E., "Beliefs and Attitudes of Hospital Inpatients About Faith Healing and Prayer," *Journal of Family Practice*, 1994; 39(4): 349-52.

A national poll of 1000 adults found that while 63% believed that physicians should talk to them about spiritual health, only 10% indicated that their physicians had done so.[50] Furthermore, only 11% of 146 family physicians in Vermont reported that they frequently or always addressed religious issues with patients. Most of the 135 patients in the study did not recall physicians addressing those issues, although 40% thought they should.[51]

This neglect of spiritual issues has many roots. Health professionals are typically less religious than the general public,[52] and as a result, the professional culture in medicine has often minimized the importance of religion. This bias is manifest in the frequent neglect of religious variables in clinical research protocols and clinical practice.[53] Furthermore, there is little training in medical education designed to equip physicians with the tools to address spiritual issues. Given this professional neglect, disinterest and lack of training, it is not surprising that so many physicians are reluctant, if not even fearful, to address spiritual issues.

However, this does not explain why physician clergy share this reluctance. Presumably, physician clergy have the training, interest and motivation to discuss spiritual issues, yet they reported discussing these issues no more frequently than secular physicians. Drawing from comments throughout the survey, the most frequent impediment appeared to be fear of offending patients or colleagues. Furthermore, routine and systematized approaches to spiritual health require breaking the inertia of medical culture. Some worried that such iconoclastic approaches would invite social stigma or

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[50]McNichol, T., "The New Faith in Medicine," *USA Weekend*, April 5-7, 1996: 4-5.

[51]Maugans, T.A., "Religion and Family Medicine: A survey of physicians and patients," *Journal of Family Practice* 1991; 32(2): 210-3.

[52]Maugans, T.A. See also Begin, A.E., "Religiosity of Psychotherapists: A national survey," *Psychotherapy*, 1990; 27: 3-7.

[53]Craigie, F. C., et. al., "A Systematic Analysis of Religious Variables in the Journal of Family Practice," *Journal of Family Practice*, 1994; 39: 564-8. See also: Dowell, E.H., et. al., "No Room at the Inn?: Neglect of religious variables by clinical epidemiologists," *Clinical Research*, 1993; 41: 516A. See also: Larson, D.B., et. al., "Systematic Analysis of Research on Religious Variables in Four Major Psychiatric Journals, 1978-1982," *American Journal of Psychiatry*, 1986; 143(3): 329-34.

professional censure and isolation. Perhaps these patterns of practice will change as more physicians realize that the vast majority of patients want their physicians to include consideration of spiritual and religious issues in their health care.[54]

15. How do you deal with the diversity of the patient population? Does your status as "ordained" interfere with eliciting patient stories--especially regarding sensitive issues like sex, smoking, alcohol, drugs and teenagers? Is it difficult to reconcile the "non-judgmental" stance of medicine with your religious convictions?

This was the most misunderstood question of the survey, and therefore, since the burden of clarity rests on the author, it was poorly written. The question was intended to probe the potential conflicts between the separate cultures of religion and medicine. However, two buzzwords distracted the reader's attention. In the current "politically correct" intellectual climate, "diversity" is a buzzword for all things good, and "judgmental" is a buzzword for all things bad. Therefore, many people missed the intent of the question, and deployed some standard argument about the need to "celebrate diversity." Others carefully insisted that diversity is an essential and rewarding part of medicine and ministry. Furthermore, nobody wanted to be perceived as judgmental, and they offered arguments to show how neither physicians nor clergy are judgmental.

> *"Being ordained is far less important than obvious caring attitude."*
>
> *"Primarily a listener does not judge."*

They established their non-judgmental stance by either 1) appealing to medicine's injunction to never judge the patient by maintaining perfect equanimity, or 2) elaborating a solid theological argument that only God judges, and individual humans should keep out of God's business.

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[54]In composing this section, I am indebted to Dale Matthews' unpublished lecture notes: "The Faith Factor: Is religion good for your health?" See also: Matthews, D. A., with Connie Clark, *The Faith Factor: Proof of the healing power of prayer*, New York: Viking, 1988.

The intent of the question was to probe the potential conflict between the different cultures of medicine and ministry. On the one hand, an important tenet of modern medicine is Osler's notion of equanimity in all cases. For good reason, Osler insisted that the patient must be comfortable and safe from judgment if the physician is to elicit the entire clinical story. This virtue of equanimity is reinforced by our culture's epistemic relativism in all matters of moral value.

On the other hand, epistemic relativism is not what the general public expects from the clergy. Cultural expectations, not all of them favorable, are projected onto the clergy. Any priest, particularly a female priest, can describe how she is treated differently when she walks down a street wearing a clerical collar. This cultural projection onto the clergy may not be theologically accurate, but there is no time to explain the distinction in a fifteen minute office visit. Therefore, at least on the surface, there may be a conflict between medicine's equanimity and the moral realism of the church as projected onto the clergy. This question was intended to investigate some of the tensions between these two apparent poles.

Surprisingly, a few physician clergy commented that their status as clergy actually improved their ability to elicit certain parts of the patient's story. However, this was not common, and although several recognized that the cultural projections onto clergy might impede their work as physicians, a surprisingly large proportion failed to distinguish between the public persona of "priest" and their own personal theology.

> *"It may interfere with eliciting histories--I know patients and staff who have modified their language for my benefit."*
>
> *"I don't bring up my ordained status --help avoid extra inhibition in obtaining social history."*
>
> *"I don't wear a roman collar...I am the doctor...my service has to be the best medical care I can offer."*
>
> *"In my experience, I hear more about the patient's sex life, smoking, alcohol problems, and drug usage as a doctor/priest than I did before ordination."*

> *"Being a priest has never interfered with eliciting patient stories in sensitive areas. In fact, I think it may make it easier."*
>
> *"My status as ordained has not changed my style in working with my patients."*

Regarding the specific issue of medical equanimity, many of the respondents accepted without criticism the medical injunction to moral relativism. However, several respondents did recognize that the issue was more complex.

> *"I find medicine generally more judgmental than our [the Episcopal] tradition."*
>
> *"Yes, it is difficult to be "non-judgmental" in the face of what I might consider sin...the ability to absolve would be useful."* [This is a deacon. Only priests may pronounce the absolution of sin.][55]
>
> *"I doubt that we're ever truly "non-judgmental" as physicians, the inner conflict for me comes when I try to live in the tension between one of my "judgments"(deserved or undeserved) and a strong religious/moral conviction."*
>
> *"As far as being non-judgmental as either a doctor or a priest, that is nonsense for both are judgmental--hopefully judgmental of a lifestyle and not judgmental of the person. There are lifestyles that are very self destructive whether you view them from the standpoint of either a doctor or priest."*
>
> *"Before and after ordination I never had any trouble telling patients their behavior was destructive."*

Although Episcopal theology has embraced a post-modern approach, the church does not embrace moral relativism. At their ordination, the clergy vow to "solemnly engage to conform to the doctrine, discipline and worship of The Episcopal Church."[56] If this vow is taken seriously, there are times when it might be difficult for an ordained physician to maintain the equanimity and value-neutral position that is prevalent in medicine. Furthermore, given their unique training, it was hoped that these physician clergy might be leaders of a rigorous critique of the relativist epistemology dominant in current medical culture. However, except for a few notable exceptions, these clergy acquiesced to the epistemic relativism of our society.

Before concluding this section, it is appropriate to reinforce the earlier observation that the question was poorly written. It is entirely possible that these

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[55]Note that this issue is particular to Episcopal and Roman Catholic polity which observe the sacrament of confession and absolution.

[56]*The Book of Common Prayer*, p. 562.

physician clergy would have given much more sophisticated answers if the question had been more clear.

16. How, if at all, do you minister to colleagues and staff?

Of the 34 responses to this question, the majority [56%(19)] stated that they ministered to staff only on rare occasions. Some had not even considered the possibility of ministering to colleagues and staff. Others deliberately chose to confine their ministry to a parochial environment [15%(5)]. The approach was passive rather than pro-active, emphasizing listening skills and exemplary living. Some mentioned fears of offending their colleagues. However, fully 29%(10) routinely ministered to staff. One person noted that although he segregated his roles when interacting with patients, he considered interaction with staff and colleagues a primary focus of his ordained ministry. Several people noted that ministry to colleagues was one of their most important ministries.

> *"Very cautiously until they ask questions."*
>
> *"By example only. I rarely discuss my current seminary journey with my colleagues."*
>
> *"I try [to minister] by example. They [colleagues] left me in quiet while scrubbing knowing I was praying for my patients on the operating table."*
>
> *"They look to me for leadership."*
>
> *"Mainly through skilled listening and prayerful response."*
>
> *"Yes...by listening. This was one of my most important ministries."*
>
> *"This happens often. People are hungry for satisfying experiences, and [they] take opportunities to pray."*
>
> *"Quite a bit...pastoral support, counseling and emotional support even of non-Christian colleagues and staff."*
>
> *"I do minister to colleagues and staff by praying for them (and letting them know it). I also minister to them by modeling and enabling healthy behavior by allowing conflicts to come out in the open so they can be dealt with, promoting gentle confrontation when possible,...[and] providing workshops and staff meetings that teach colleagues and staff about self-understanding and good communication."*

17. Do your colleagues know that you are ordained? If so, what do they think? Are they generally supportive, ambivalent, discouraging?

Fully 95%(37) answered this question, and the great majority indicated that their colleagues knew of their ordination. Only one person deliberately concealed his ordination. Twenty-two percent (8) shared their ordination with only a few colleagues and friends whereas the majority [76%(28)] freely shared the information with many of their colleagues. Very few described open disapproval from colleagues, but they did report significant ambivalence. *"Perplexed and curious would be better words."* Of note, some of the greatest support was reported by physicians living in the "Bible Belt."

> *"Most cannot believe it or even deal with the issue."*
>
> *"Verrrrrry supportive."*
>
> *"Comments are universally positive/supportive."*
>
> *"We don't talk about it...they do know."*
>
> *"Usually supportive but one colleague said to me: "I don't understand why you're doing this. Medicine is about science and religion is about superstition."*
>
> *"Yes, it is OK as long as I am competent in my profession and loving/accepting of my colleagues."*
>
> *"Most view me as an odd duck, a Dr. Jekyll/Mr. Hyde."*

18. Have you encountered resistance from colleagues who find the combination of medicine and ordained ministry impossible, irresponsible or even malpractice?. If yes, please describe.

This question assumed that bivocational ministry would be an uphill battle where physician priests would constantly struggle to justify themselves. However, this assumption was not confirmed. Of the 35 responses, fully 83%(29) never encountered resistance from colleagues. Only 11%(4) encountered institutional resistance, and it was from the church, not medicine. As one person noted, "*The persecution I expected never*

materialized." Surprisingly, two people (6%) reported significant resistance from their ordained colleagues.

> *"No, but I remember hearing about someone else."*
>
> *"A colleague said, 'make up your mind, be a priest or doctor, not both.'"*
>
> *"On occasion, but basically in a friendly fashion...[and then for the] duration of my residency only."*
>
> *"No--only some confusion and uncertainty about how to "manage" me."*

Although the lack of resistance is clearly a credit to the diplomacy of this cohort, this finding might be related to the fairly rigid segregation of roles recommended by these physician clergy. In fact several respondents commented that resistance was appropriate if boundaries between vocations were blurred.

> *"NO! I keep my two lives separate."*
>
> *"I had a medical officer under me who was aggressively evangelical. I found such behavior an abuse of power."*
>
> *"No--but I did observe a Roman Catholic priest/physician who made rounds in a clerical collar in a secular hospital, and made pastoral visits to patients he was assigned to as a resident. I think that resistance [in this case] was appropriate."*

19. Do patients ever switch to other physicians because of your dual vocation? If yes, please describe.

Of the 36 responses to this question, 89%(32) responded, *"NO," "not to my knowledge"* or *"if they did, they never told me."* Not a single report of patient switching was recorded. However, 11%(4) reported that the opposite occurred: *"Are you kidding? They switch to me because of it!"* It appears that some patients prefer physicians who are also ordained.

20. Has your dual vocation interfered with your professional goals in either medicine or the church? If yes, please describe?

Again, this question anticipated interference, discrimination and resistance from the medical profession toward physician clergy. However, this assumption was not corroborated. There was not a single report of professional interference or discrimination. In fact one person wrote, *"in medicine, it has proven more an asset than a liability."* Of the 35 respondents, 66%(23) encountered no interference at any time during their professional career.

However, 11%(4) did describe resistance and interference from the church. For example, after two years of residency one surgeon felt an *"awakening"* which inspired him to seek ordination. However, the bishop discouraged the idea of dual vocations until 25 years later. Even then, the bishop limited him to the vocational diaconate, refusing to ordain him priest. Another person wrote, *"I am at the top of my [medical] profession...It is hard to be taken seriously by some parochial clergy and bishops."*

The greatest source of interference with professional goals was time [23%(8)]. Many people remarked that the demands of dual careers prevented them from achieving all their goals, especially goals within the church.

> *"It is difficult at times to serve on Sunday and try to be on call, round in the hospital and sing in the choir."*
>
> *"Yes, I wanted to be a rector, but can't."*
>
> *"Because I am a worker priest, I can't make it to all the [church] meetings."*
>
> *"Major problem is that many clergy activities happen during the week so I feel a bit marginalized."*
>
> *"In the church I am not free to have a full pastoral responsibility as a rector....In medicine I am not willing to be in a situation of rejecting patients for financial reasons, and hence I have been working in public service situations."*
>
> *"I am financially poorer as a result of the combined careers, but richer in every other way."*
>
> *"I worry about trying to serve two masters, but I really have only one Master. Time constraints limit things...I am a board eligible deacon not a board certified priest--what does that say to you? Am I a good second-in-command?!"*

21. Given that ordained ministry and medicine are both very demanding, how do you "re-charge?"

The approaches to "re-charging" ranged widely, but common responses included hobbies(67%), family(56%), prayer(56%), vacation(38%), and personal reflection(33%). Most people recognized the need for rest and refreshment, but their approaches differed greatly. Some compartmentalized their work and recreation, subscribing to a "work hard, play hard" philosophy. Others were much more reflective, detailing the ways they kept their minds and souls alive in the hectic pace of life. *"I have a tendency to almost burn out...[but prayer, Bible study, community and reflection] keep me centered."*

Although 33% described some discipline of deliberate reflection, it was surprising that these physician clergy did not exhibit a greater tendency to reflect deeply about their professional lives. It was assumed that their religious perspective would moderate the corporate culture of physicians which is comparatively less reflective than the clergy.

For many reasons, the medical profession emphasizes practical application over introspection. There is much to do, the stakes are so high, and there is rarely time to reflect. The clinical demands on practicing physicians are so extreme that the task of professional reflection is often relegated to consultants in ethics, policy or administration. Although there are attempts to improve the curricula of medical schools so that young physicians might enhance their self-awareness and moral character, the problem is more systemic.

Perhaps there is no need for physicians to be more reflective. As it stands, the profession delivers outstanding medical care. However, with the rising importance of medical ethics and alternative health care, it is perhaps time for medicine to improve its corporate culture of reflection.

22. How, if at all, have your two vocations influenced your theology? Specifically, what is your theology of suffering and death? How do you view the theological nature of disease?

Although there were several unsophisticated answers, this question elicited some of the most extended and complex responses. Fully 85%(33) responded in some way, and the level of theological argument was markedly better than the responses to the question regarding the theological foundation for bivocational ministry. Many people commented that their theological education better equipped them to deal with issues of suffering and death in their medical practices. Others commented that, in contrast to parochial clergy, their experience in medicine afforded them a more intimate encounter with death, and a broader perspective on theology.

> *"Most theologians are utterly naive and ignorant when they speak of 'the body.'"*
>
> *"I can hardly separate the two: medicine and theology. Medicine taught me about feelings...Medicine has helped me be comfortable with questioning God and my faith and looking at hard issues."*
>
> *"Medicine provides one possible response (with its own set of tools, knowledge, and discipline) to the wounded character of human life. It is not the only one, or even the most important one, but it is one with possible integrity."*

In responding to this question, most chose to address the basic question of theodicy: How can a good God permit evil? Or in the more popular idiom: Why do bad things happen to good people? Life in medicine exposes physicians daily to graphic examples of how bad things happen to good people. For the physician, the problems of theodicy are not theoretical—they are daily realities. Many of the respondents developed fairly orthodox positions which root the cause of evil not in God, but in some notion of a sinful, fallen or broken creation. This broken state of affairs is somehow related to the human exercise of God's gift of free will. The theological task is not to understand why this state of affairs exists, but to redeem the fallen state of affairs by connecting human suffering to the suffering of Christ.

> *"Suffering is a relative matter. Some suffer more grandly than others. I feel a natural sense of compassion and mercy.*
> *Physical death is absolute*
> *Spiritual (eternal) life is available to all.*

> *Spiritual death may occur and is a disaster beyond all else. The writers of Genesis Chapters 1-12 did a truly remarkable job of sharing a theological view of mankind's dilemma--how and why disease and death and evil came to be. The gift of the freedom to choose means there will always be consequences (some good, some bad). Our choices alienate us from God, self, nature, other persons and nations. Truly and totally accepting Jesus as [the] Lord and Savior of life brings us (allows us a way) back to God."*
>
> *"I have tended to see our condition in this world as one of "sickness"--spiritual, mental, physical, [and] social ills proclaiming our need of the Great Physician. ...God is the God of healing who allows disease and suffering, but actively works to heal. Death is tragic, but the final means to overcome evil."*
>
> *"Although you can't tell someone this, many find in their suffering a participation in [the] life and work of Christ."*
>
> *"Bad things happen to good people--suffering is [an] inevitable result of the freedom God has created us in." [He goes on to state that God desires our good, but this is not always obvious, and frequently becomes a matter of faith.]*
>
> *"I still struggle with whether suffering is really related to sanctification. Pain should be relieved whenever possible. Healing is a God-given gift that is both secular and sacramental.*
>
> *Disease is a reflection of the brokenness of creation, a manifestation that the Kingdom of God is here, but not yet, not entirely. What Christians are called to do (whether they have an M.D. or not) is to be a healing and reconciling presence to others."*

In a similar, but slightly different approach, several people suggested that the central issue was meaning. The challenge is not to explain why suffering exists--it is simply a fact of the human condition. Instead, the challenge is to discover what that suffering might mean.

> *"Whenever I was able to stop asking the question 'why?' with respect to suffering and death (a question learned largely in medical school), I was freed up to begin asking 'what?' 'What does this mean?' (a theological question). For me, many of the answers to 'what' are found in the wounded healer paradigm."*
>
> *"I don't feel called to eliminate suffering, but to help people understand its nature as part of human existence and freedom."*

Although the majority expressed some version of the standard Christian approach to these questions, a significant proportion [42%(14)] shared more unusual, and sometimes less orthodox, approaches to suffering and death. One person commented on the role of redemptive suffering. Another proposed a potentially heterodox notion of

"random evil." One person's comment implied an intriguing theology of theosis.[57] Another chose the Biblical and time-honored approach of side-stepping the issue by referring to the story of Job.

> *"Suffering is secondary to random evil which God allows, but does not personally send to an individual. Most are innocent victims of random evil. God wants healing."*
>
> *"Until we and the kingdom are complete, 'bad things will happen to good people."*
>
> *"Job 38" [For those unfamiliar with Job, chapter 38 is the climax of the story of Job when God speaks out of the whirlwind and says, "Who is this that darkens counsel by words without knowledge? Where were you when I laid the foundation of the earth? Who determined its measurements--surely you know!"]*
>
> *"Deepened awareness of God's love. Disease is the Devil's spawn."*
>
> *"Death is often bad--but some things are worse. Faith inexplicably makes both [suffering and death] more manageable."*
>
> *"Disease is part of how the world works. It is morally neutral for the most part."*
>
> *"Christ suffered greatly on the cross. Some(most?) of us will suffer greatly at times in our life. From birth we move toward death (and new life) and throughout life we die over and over again in many ways to be re-assured over and over again by renewed hope for life."*
>
> *"As [a family practitioner] I've seen it all. God and his people are here during and after the suffering and pain. Joy and suffering, pain and pleasure, are simply part of God's mysterious creation."*

Finally, there were some responses which took a more practical approach. Rather than developing a theology, they simply pointed to practical ways their practice of bivocation is influenced by theology.

> *"Suffering is to be relieved --my colleagues are a bit stingy with analgesics. Death is the door to eternal life. Disease is part of God's plan. I must accept it, treat it, relieve."*
>
> *"I have, since becoming a med student, considered myself a middleman between God and his creation."*
>
> *"I am less aggressive about futile resuscitation attempts than most."*

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[57]Theosis is the technical term for those theological traditions which describe ways in which humanity is "divinized" by adoption into the Godhead. It is a theology of how humans, to a limited extent, become divine through salvation.

23. How, if at all, did finances influence your vocational decisions?

This question did not inspire detailed comments, but of the 35 responses, 69%(24) denied that finances influenced their vocational decisions. However, it is clear that these physicians enjoy a more affluent standard of living than most clergy.[58] Only 9%(3) earned less than $75,000. Forty-three percent (15) earned between $75-150,000; and 49%(17) earned between $150-250,000. Several of the respondents recognized that they had grown accustomed to this standard of living, and 20%(7) felt obliged to continue practicing medicine in order to support themselves and their families. Alternatively, several people used their wealth and earning potential to support their practice of ordained ministry.

> *"Only that I was financially able to give up practice for seminary and full-time ordained ministry."*
>
> *"A comfortable retirement from medicine allows me to pursue a theological education and career."*
>
> *"I had to struggle with my fears about decreased financial security, but overall, have not let this deter me from ordained ministry."*
>
> *"I grew up in Britain where medicine and money [are] not connected...Right now I am staying in full-time medicine to qualify for a pension."*
>
> *"Self employment of medical practice allowed the time and means for me to seek the fulfillment and growth for both vocations."*
>
> *"Medicine pays five to ten times more so it is difficult to justify ministry financially, given a shortage of time."*
>
> *"Not really, though I clearly earn my money as a physician."*
>
> *"Fortunate to manage loans which I was able to pay back--state medical school was not as expensive in 1973."*

24. Briefly describe your personal piety and prayer life.

This question was surprisingly misunderstood. Many respondents attached a pejorative connotation to the word "piety", stating *"I do not consider myself a pious*

[58]As documented in Question 5, p. 27, the average annual compensation package for clergy in the Episcopal Church was $45,434 in 1994. (Data from Church Pension Fund).

person." However, the technical sense of the word simply refers to the private patterns of personal devotion, and these patterns of devotion were the intended subject of this question. It is unfortunate that the pejorative connotation of piety persists even among the clergy.

Looking beyond this misunderstanding, there was a predictably wide range of response, but most described some form of daily prayer [74%(29)]. For many, this took the form of the daily offices of Morning and Evening Prayer [31%(12)].[59] However, there was a general recognition that the demands of medical practice often interfered with a consistent discipline of prayer. A smaller proportion described specific disciplines of spirituality to include retreats [13%(5)], journalling [5%(2)] and anglo-catholicism [8%(3)].[60] Although there were a small number of anglo-catholics, these people described the most detailed and developed form of personal devotion. It is perhaps interesting to note that of those who left medicine for ministry, fully 27%(3) described an anglo-catholic piety. Finally, several people encouraged the use of spiritual directors to guide their prayer lives and hold them accountable.

> *"I do not consider myself as a pious person...[but my] personal prayer includes traditional and non-traditional prayers of past."*
>
> *"I do very little conscious thinking about this...[I] do not see [my]self as pious."*
>
> *"Tend to spend too much time intellectualizing."*
>
> *"Honestly, meager at times--night call, CCU, rounds, papers add up."*
>
> *"Third order Franciscan."*
>
> *"[I] pray frequently, if briefly, during the day. [I] pray Morning Prayer and sometimes Evening Prayer--not as often as I should. [I] celebrate Holy Eucharist on Tuesdays and Sundays."*

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[59]Morning and Evening Prayer are formal worship services contained in the *Book of Common Prayer*. They include specific prayers as well as a cycle of appointed scripture readings. In a two year cycle, the entire Old Testament is read once, and the New Testament is read twice. Until 1979, all Anglican clergy vowed at their ordination to recite daily Morning and Evening Prayer.

[60]Anglo-catholicism is the tradition of Anglicanism which started in the mid 19th century. In addition to differences in theological argument, anglo-catholics practice a piety very similar to Roman Catholicism in the Middle Ages: the rituals are complex, the liturgy is high, and there is a strong reverence for all the saints, especially the Blessed Virgin Mary.

25. What are the tensions between the two vocations?

Of the 34 responses to this question, the most common tension identified was time [53%(18)]. With too many demands in either profession, there was never enough time to do everything. However, fully 41%(14) stated that there were no tensions between the two vocations. Of note, this group represents two distinct populations: 1) those who totally segregated their roles; 2) those who totally integrated their roles. In contrast, the respondents who identified tensions between the two vocations were most likely to be those who only partially integrated their roles.

It is not clear whether this unexpected relationship between integration and augmented tension is causal or symptomatic: Partial integration may be a symptom of internal tensions perceived by these physician clergy. On the other hand, the inability to commit one way or the other to integration or segregation might itself cause tension because tension is likely to be more acute if the relationship between the two vocations is constantly changing according to context. Although the majority of respondents perceived tensions between the two vocations, the majority also integrated their vocations only partially. It might be argued that the tension could be resolved if each physician cleric were to choose between completely integrating or segregating their roles. This conclusion is perhaps supported by the fact that of those physician clergy who took this choice to the extreme, leaving one vocation for the other, 50% stated that there were no tensions between the two vocations.

> *"Competition of time and emotional energy...never get any free time just for me."*
>
> *"Constant schedules for call and service with the church put a burden on my time. Sometimes my family feels pulled by the church."*
>
> *"What do you do when your pager goes off while you celebrate communion."*
>
> *"I may be naive, but there has not been much tension between these two expressions of my Christianity. Mysteriously, I have not been bothered during services for medical reasons--even while on call."*

Beyond this superficial level, there were several profound critiques of the medical and theological cultures. Several people commented on the institutional tensions between medicine and the church. In particular, the previously identified theme of institutional church resistance resurfaced with greater specificity.

> *"Church and medicine, as institutions, are often aggravating."*
>
> *"Professors at seminary who act out of their own insecurity [create tension]."*
>
> *"Prejudice from the fundamentalists in the Episcopal Church."* [Bible Belt]
>
> *"[There is tension in finding a] church/congregation/rector/bishop who: a) understands; b) cares about what I do. You will see I am a scientist, not a physician, but it may be that my bishop has still to grasp that point(symptomatic?!)"* [This physicist priest received the survey because his bishop identified him to me as a physician priest.]
>
> *"Physicians are concerned that clergy may interfere...Clergy see physicians as uncaring."*
>
> *"Sometimes I am self conscious around my peers. Faith and reason are perceived like oil and water in the medical setting."*
>
> *"I am not sure the tensions are between the vocations, but perhaps in individuals."*
>
> *"[I find tension in] knowing the worldly scientific answers and treatment of disease, especially emotional and mental; and then knowing the potential of spiritual power available."*
>
> *"I could not see how to do both at the same time. To do either, at least for me, demanded 100+%"* [This physician left medicine to be a full-time priest.]
>
> *"Theologians have washed their hands of the soul...psychotherapists avoid God...That leaves me in the middle of nowhere."* [In addition, this person was deeply concerned about the "suppression" of recent research on the use of faith and prayer in healing.]
>
> *"Boundary issues are interesting."*

26. In your opinion, is it possible to integrate both vocations of ordained ministry and medicine? Why or why not? Would you recommend such an integration to someone considering a bivocational ministry, and what advice would you give?

This question elicited some of the most satisfying, thoughtful and extended responses. By and large, the overwhelming response was "yes, it is possible to integrate

the two vocations." However, many qualified their affirmation with several specific reservations. Others acknowledged the possibility of integration even if they did not or could not integrate their own vocations. Results were similar in all groups of physician clergy including those who do not pursue both vocations, having left one for the other. The results are found in the following table.

Is Integration Possible?

	All [N=45(86%)]	Bivocational [N=36(92%)]	Monovocational [N=9(75%)]
No	9%(4)	8%(3)	11%(1)
Yes	91%(41)	92%(33)	89%(8)
Yes, absolutely	53%(24)	64%(23)	11%(1)
Yes, with reservations	20%(9)	22%(8)	11%(1)
Yes, even though I don't	9%(4)	---	44%(4)
Yes, even though I can't	9%(4)	6%(2)	22%(2)

Because each individual voice was unique, the remaining text presents many extended excerpts from the surveys. However, they are grouped according to shared themes. For example, several respondents commented that although integration was possible, one vocation would predominate at any given time, subordinating the other vocation.

> *"They must be integrated, but at any moment in time, one may be overt and the other covert."*
>
> *"In the USA this would be very difficult as a bivocational ministry. I believe one must dominate--and if the ordained ministry dominated, it would be almost impossible to keep up with the rapid changes in medical practice."*
>
> *"Yes, it is possible, but I believe one will predominate and the other will be subordinate. I have chosen full-time ministry. Therefore medicine will be subordinate. This precludes medical practice which must by nature be given one's 'all.'"* [This priest left medicine to pursue full-time ministry.]

Others commented that complete integration would only be possible in the environment of foreign missions. Presumably, missionary work allows greater flexibility and control to integrate both vocations without interference from either church or medical institutions.

> *"Yes, but I doubt that a high grade of integration would be possible outside of a special mission field situation."*
>
> *"Yes, but I would doubt that a simultaneous call would be common unless it was a call to the medical mission field."* [This person was called to his second vocation late in life, and now has a two year experience of integrating both vocations.]

Several commented that the vocations of medicine and ministry compliment each other well, mutually supporting each other.

> *"Did you know Samuel Seabury was a physician? I sometimes wonder if God "cross-fertilizes" vocations, denominations, races, nations, etc. as part of [the] healing process of creation."* [Seabury was the first bishop in the United States.]
>
> *"Yes, I served the Lord as a surgeon and healer--but so much more [now that it is] combined with my ministry. I learned to help heal body and soul."*
>
> *"I can only say that my background in each has been very helpful. Again, I no longer practice psychiatry as a profession."*
>
> *"Yes-It places one in a different arena where ministry tends to shy away from, and an area where people are really looking for an intellectual understanding of those things that an MRI, CBC or Freud do not explain."*

Along similar lines, others suggested that the integration of both vocations might provided an appropriate mutual critique of science and religion. As scientists, physician clergy are perhaps uniquely equipped to help the church accept and understand the claims of modernity without reducing faith to scientific determinism. As theologians, clergy physicians are perhaps uniquely equipped to restore some of medicine's own rich moral tradition as it seeks to establish contemporary moral guidelines. In other words, physician clergy may provide an attractive alternative to Herbert Benson's approach of reducing all spirituality to "the relaxation response."[61]

> *"I think bivocational goals are very exciting. There are so many problems in medicine that the medical model cannot address adequately. So many chronic illnesses have underlying faith issues that need attention. We live in such a secular society [in which] things of the spirit are not addressed. Medical schools seem to be a great repository of secularism--I am not sure what the model will be, but there must be a synthesis of the rational and the spiritual."*

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[61]To my understanding, Benson argues that religious practice and belief is simply a highly adapted technique of eliciting the "relaxation response" which is similar to a meditative state. My most extensive exposure to Herbert Benson's thought is based on notes and publications from his lectures at his "Spirituality and Healing" conference in Boston on December 12-14, 1998. Copies of these material are available from the Harvard Medical School Department of Continuing Education. See also: Benson, H., *The Relaxation Response*, New York: Morrow, 1975 or in future, *Timeless Healing: The Power and Biology of Belief*, New York: Scribner (in press).

> *"Yes--I think we bring a perspective on spirituality to medicine and a scientific rigor to theology. [The] ministry of healing is a clear connecting point."*
>
> *"I would recommend it. Right now I believe it is more important than ever that good theology inform culture about science and vice versa."*
>
> *"Yes, to me, they go hand in hand. Unfortunately, our training as scientists doesn't often allow for expressions of faith, spirituality or belief."*

Many respondents allowed for the possibility of integration, but they mentioned specific challenges such as time management, choice of medical specialty, choice of ministry or the pitfalls of preserving the integrity of both vocations.

> *"Yes, [but] be sure that you are called to the ministry. I have seen many forget their ordination vows and practice only medicine."*
>
> *"I have struggled (and continue to struggle) to become one person connected to the inner core of my being...where the priest and the physician can live together in peace, empowered and informed by God's Spirit."*
>
> *"Yes, but I am not sure about trying to train for both at the same time." I could see both ministries integrated in a small hospital under church auspices."* [This deacon works for a state hospital, and she finds the state regulations restricting.]
>
> *"Yes, be yourself, pray, consult a spiritual director. Yes--but you must choose a specialty in medicine that will guarantee free time to exercise the ministry. Furthermore, choose a specialty that makes sense. For example: family practice, internal medicine, psychiatry--not pathology."*
>
> *"Yes, but how about a diaconate??? You would feel drawn too hard to be a priest, and it is tough with a full-time job to be a priest only on the weekend. It is tough when I have to prepare a sermon."* [This is a deacon.]

Several people argued that it was impossible or inappropriate to integrate both vocations. However, there were also those who argued that it was impossible to separate the two vocations because they grew from the same gifts and inspiration.

> *"I don't believe for most people full-time ministry can be integrated. No I would not recommend."*
>
> *"Not realistic: If you seek excellence in medicine that is what you must do--research, teaching, administration, [and] patient care demand a great deal. I prefer to have my current clerical skills inform my medical skills. It is not really possible to do both totally."*
>
> *"I would question what they hoped to accomplish, why they needed both. While there may be special situations, I don't think they are common. Ordination does not make a person a better Christian--[it] only gives certain sacramental powers. Of these, only celebration of the Holy Eucharist is not available to [the] laity. So why does a doctor who intends to practice medicine need ordination?"* [This physician left

medicine to become a full-time priest. He clearly articulates a fairly restricted and functional view of ordination.]

I think it is impossible to compartmentalize the two vocations, except perhaps in scheduling time. They both spring from the same source, use the same gifts, and are exercised by the same unique child of God. My advice to someone considering a bivocational ministry is to test both calls against an intensive discernment of gifts. Are the gifts which give you the deepest pleasure in using the ones that you will use meaningfully in medicine, as a priest/deacon, or in a combined vocation?"

Finally, several people emphasized the need for humility in combining these two vocations. They insisted that success depends on following God's lead without trying to control or micro-manage the specific ways the vocations are integrated.

"It is certainly possible, but as with any human endeavor, it can become impossible when we work without guidance from the Father."

"Maybe. When I started all of this, I had many expectations, most of which were probably too grand, but nevertheless my moments (and there have been several) have exceeded my wildest expectations...It was as though I had seen the very gates of heaven, and had been embraced by Jesus himself."

"Yes--I found that if I call time, 'mine' and if I am very possessive of 'my time' there is never enough. If I give 'my time' up, and do what I am called to do, there is time enough...for worship, prayer, work, rest, recreation, family life and exercise The energy that we [waste] worrying about whether we have time to do this or that is tremendous. It makes more sense to expend that energy in other directions."

*"Yes, but it requires a willingness to share two worlds with colleagues who will not fully understand you. It requires a great acceptance of ambiguity. It is easy to get lost in activity and problem solving so prayer and some quiet are critical. It is a great life**, but you can't take yourself too seriously."*** [emphasis mine.]

C. The Last Page--Testing Assumptions

The final page of the survey was designed to elicit more quantitative data about issues such as ethics, malpractice litigation, and compensation. This section did not call for extended narrative responses. Instead, the study group was instructed to choose between several multiple choice options. As such, it was an easier part of the survey to complete, and as a result, the response rates were very high, usually above 90%. It was

intended that the same instrument would be administered to a control sample of non-ordained physicians, but this was never completed because it was not feasible to assemble a control group with similar demographic criteria of age, education, geographical location and medical specialty. Therefore, it is not possible to state with certainty how these ordained physicians differ from ordinary physicians. However, when possible, the results were compared with published statistics describing all physicians nationwide. The results point to several conclusions that may be worth confirming with a refined instrument and appropriate controls.

In the following discussion, data is drawn from the 39 physician clergy who actively pursued both medicine and ministry at the same time. The results are recorded with both the percentage and the absolute numbers. For example: 55%(total yes/total respondents).

1. Ethics

These questions were designed to test whether or not ordained physicians were more likely to be leaders in the field of medical ethics. Fifty-three percent (20/38) identified themselves as taking an active role in the field of biomedical ethics within their communities. Most of these respondents exercised this leadership within the hospital [44%(8/18)] or general setting [50%(9/18)]. Only 6%(1/18) exercised this leadership through the church. Thirty-seven percent (14/38) currently served on a hospital ethics committee.

It was assumed that physician clergy would have a more active role in the field of medical ethics, and a large proportion of these physicians did dedicate time to leadership in this field. There are no published statistics on the prevalence of physician participation on ethics committees. However, the prevalence has never been high, and with the growing popularity of non-physician ethics consultants, the prevalence is likely falling. It

would therefore appear that this questionnaire corroborates the assumption that physician clergy are more likely than their secular colleagues to be community leaders in medical ethics. However, a proper control would be necessary to confirm this conclusion.

2. Right to Die

A Gallup poll in 1996 showed that 75% of the general population "favored allowing doctors to end the lives of the terminally ill."[62] In 1991, a *Boston Globe* survey showed that "64% of the public believe that a physician should be legally permitted to give a...lethal injection."[63] The opinion of physicians is less affirming. A 1996 study of oncology patients, oncologists and the general public showed that two thirds of oncology patients and the public found physician assisted suicide acceptable whereas less than half of the oncologists supported assisted suicide.[64] A 1994 study of 1355 physicians in Washington State found that only 54% of physicians thought euthanasia should be legal in some situations. Psychiatrists were most likely to support euthanasia whereas medical oncologists were least likely. Only 40% stated they would be willing to assist if euthanasia were legalized.[65] Finally, several studies suggest that only approximately 28% of physicians would be willing to assist a patient's suicide.[66] Seventy-one percent of physicians absolutely refused to consider assisted suicide.[67]

Based on both the doctrine of the Episcopal Church and on clinical research, it was assumed that physician clergy would be less likely to support the "right to die." For

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[62]Biema, David, "Is There a Right to Die?", *Time*, January 13, 1997.

[63]Emanuel, Ezekial, "Euthanasia: Historical, Ethical, and Empiric Perspectives," *Archives of Internal Medicine*, 1994; 154: 1890-1901.

[64]Emanuel, Ezekial, et. al. "Euthanasia and Physician-Assisted Suicide: Attitudes and experiences of oncology patients, oncologists, and the public," *The Lancet*, 1996; 347:1805-1810.

[65]Cohen, J., et. al., "Attitudes Toward Assisted Suicide and Euthanasia Among Physicians in Washington State," *New England Journal of Medicine*, 1994; 331: 89-94.

[66]Emanuel, 1994. (It contains a meta-analysis of five previous studies).

[67]Shapiro, Robyn, et. al., "Willingness to Perform Euthanasia: A survey of physician attitudes," *Archives of Internal Medicine*, 1994; 154: 575-584.

example, a study of 427 surgeons found that religious affiliation was associated with a decreased malpractice claim rate.[68] Furthermore, the church has traditionally articulated a conservative stance on this issue, arguing against any form of suicide. Although the church and its ministers take great pains to address and relieve the suffering of dying patients, the official position of the Episcopal Church surrenders to God all life and death decisions: Life is considered an absolute good, and humans are at no time permitted to judge when life is no longer "worth living." However, palliation of dying patients is permitted even if it hastens death.[69]

Despite these assumptions, a surprising 75%(27/36) of the physician clergy supported a constitutional right to die. These results resemble the opinion of the general population, suggesting that these physician clergy were more likely than their secular colleagues to support the right to die. However, like other physicians, only 27%(8/30) thought it appropriate for physicians to assist in exercising that right. Many added brief narrative qualifications to their affirmation of the right to die. Sixty-seven percent (4/6) insisted that physician assisted suicide should be permitted only under strict external regulation. Seventeen percent (1/6) allowed for the possibility of physician assisted suicide, but mentioned that there is no obligation for physicians to participate. In other words, even though the right may exist, no patient can require a physician to assist their suicide. Finally, 17%(1/6) affirmed the right to assisted suicide, but absolutely rejected the right to euthanasia.

These results are surprising. My understanding of Christian doctrine and theology is that there is no "right to die." However, most of these physician clergy approved of that right, despite their vows to conform to the doctrine and discipline of the Episcopal Church. Without doubt, the issue is contentious within the church, and there is no

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[68]Adamson, T.E., "Characteristics of Surgeons with High and Low Malpractice Claims Rates," *Western Jonrnal of Medicine*, 166(1): 37-44, 1997.

[69]Panton, M., and Stannard, E., *Summary of Actions of the 1994 General Convention*, New York: The Church Hymnal Corporation, 1994.

universally accepted position. However, it is surprising that this group of physician clergy did not hold positions substantially different from either the general public or other physicians.

3. Health Care Delivery

These questions were designed to determine how satisfied these physicians were with the current system of health care delivery in the United States. It was assumed that many of them would be dissatisfied for reasons of injustice and inequitable distribution of health care resources. A general dissatisfaction was corroborated, but many were dissatisfied for unexpected reasons. For instance, the most vituperative comments were directed not at issues of injustice, but at HMOs, managed care and the conflicts with external control. Specific data are presented in the following tables.

Are you satisfied with the current health care delivery system?

Yes (satisfied):	6%(2/34)
No (unsatisfied):	94%(32/34)

Why are you unsatisfied?

Injustice to the uninsured:	58%(14/24)
Managed care:	17%(4/24)
External Control:	13%(3/24)
Other:	13%(3/24)

How should basic health care be provided?

Fee for service:	28%(9/32)
Fee for service supplemented by physician altruism	53%(17/32)
Guaranteed privilege of citizenship	9%(3/32)
Guaranteed human right	50%(16/32)
Other	6%(5/32)

These results are not surprising, and they probably do not differ greatly from the general population of physicians. It is perhaps a sign of the times that so many (94%) were dissatisfied with the current system. However, it is not clear what the respondents thought could be done to make things better. Many of these physician clergy continued to articulate positions opposed to nationalized health care even though fully half of them considered health care a guaranteed human right.

The prevalence of "rights" language in contemporary moral discourse is often divisive. Rather than building consensus, the rhetoric of "rights" is deployed by any number of constituencies in order to enforce compliance with their particular point of view. Although there are many strong arguments for extending health care benefits to all people regardless of their ability to pay, it is difficult to establish that human beings have an inalienable right to heart surgery in the same way that they have an inalienable right to free thought. Excellent health care is not a state of nature, and it is frustrating when the solid reasons for universal health care are eclipsed by convenient, but unconvincing rights rhetoric.

Although not perfect, my opinion is that universal health care should be a guaranteed privilege of citizenship in this country. It is not a right, but like social security or well-maintained roads, it should be a benefit extended to all citizens as a reflection of this country's prosperity. The questionnaire was written to include this position, but only 3 respondents chose the option. The distinction between "right" and "guaranteed privilege" is subtle, but it is disappointing that more physicians clergy did not appreciate this distinction.

4. Malpractice.

The questionnaire assumed that physician clergy would report fewer episodes of malpractice litigation. This assumption is based on several factors. First, as clergy, it was assumed that their attention to ethics and professional behavior might be somewhat more stringent. Second, and more importantly, it was assumed that physician clergy would likely exercise more effective communication skills. Research has shown that the

best prophylaxis to malpractice litigation is effective communication which conveys both medical facts as well as a respectful and caring attitude.[70]

As shown in the following chart, the results support the conclusion that physician clergy are not often sued. Fifty-nine percent were never sued, and only 5%(2/37) were ever found negligent. As would be expected, a few more 22%(8/37) had settled out of court. However, these rates are identical to the national rates of malpractice litigation. As of 1996, 41.9% of all physicians nation wide had at least one malpractice claim during their careers.[71] It would appear that, contrary to expectation, these physician clergy were not protected claims of malpractice.

Malpractice Rates

	never	1	2-5	5-10	>10
How many times have you been sued?	59%(22/37)	27%(10/37)	14%(5/37)	none	none
How many times have you been found negligent?	95%(35/37)	3%(1/37)	3%(1/37)	none	none
How many times have you settled out of court?	78%(29/37)	16%(6/37)	5%(2/37)	none	none

The final question in this section was, "When compared to colleagues in a similar type of medical practice, your rate of malpractice litigation is: greater, lesser or about the same?" Clearly this question only seeks the respondent's self assessment, but it is interesting that 67%(22/33) reported a lesser amount of litigation in their own practice. Nobody reported a greater rate of litigation, and 33%(11/33) reported that their rate of litigation was about the same as their secular colleagues. This suggests that, at least by self-perception, these physicians experienced less litigation during their entire career.

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[70]Beckman, Howard, "The Doctor-Patient Relationship and Malpractice," *Archives of Internal Medicine*, 1994; 154:1365-1370. See also Levinsion, Wendy, "Physician-Patient Communication: A key to malpractice prevention," *JAMA*, 1994; 272(20): 1619-20.

[71]Gonzalez, M., et. al., eds., *Socioeconomic Characteristics of Medical Practice*, 1997/98, Chicago: AMA Center for Health Policy Research, 1998, p. 41.

However, as mentioned previously, national statistics suggest that this self perception is probably not accurate.

5. Compensation

These questions were designed to discover if physician clergy followed different patterns of compensations than secular physicians. It was thought that physician clergy might donate more of their practice to serving the underserved and under-insured. It was also thought that they might work fewer hours in order to free time for their ordained ministry. The results are found in the chart below. By their own report, 43%(15/35) stated they made less money than their secular colleagues. Fifty-one percent (17/35) reported earning equivalent compensation, and only 9%(3/35) reported earning more. Compared with national statistics, it appears that their self perception is roughly accurate. These physician clergy worked average hours, and many earned a competitive wage. However, it appears that a significant portion may have earned slightly less than the national averages. However, the reported earnings of these physician clergy might be artificially low because many are retired, and they are either reporting their current income or their income during their active careers, not adjusted for inflation.

Physician Compensation

Physician Clergy		All Physicians[72]		
	(1996)		(1996)	(1992)
Work hours/week	50± 17	Work hours/week	51	
Less than $75,000/year	17%(6/35)	Mean income x 1000	$199	$181
$75-150,000/year	51%(18/35)	25% income/year	$120	$100
$150-250,000/year	23%(8/35)	50% income/year	$166	$150
More than $250,000/year	9%(3/35)	75% income/year	$240	$230

[72]Gonzalez, et. al., pp. 110-113.

6. Patterns of Practice

These questions sought to discover how these physician clergy organized and used their time in their medical practices. As discussed in the previous section, it was assumed that these physician clergy would probably dedicate more of their time to under-served and under-insured populations. It was also thought that they might spend more of their time interacting with patients on personal and spiritual levels. These are difficult issues to address, but the results were as follows.

What percent of your practice do you dedicate to charity?	22% ± 23%
What percent of your practice treats patients from the underserved populations?	38% ± 37%

These results suggest that a significant proportion of these physician clergy did dedicate a large part of their practice to the under-served and under-insured populations. However, it is important to note the extremely large standard deviation in these numbers. Both questions elicited responses ranging from 0-100%, and it is therefore difficult to draw any conclusions from this data. Notwithstanding the large variance in the data, it is not clear that these physician clergy differ from secular clergy in their willingness to care for the poor.[73] Furthermore, it must also be noted that these physicians considered the service of Medicare patients to be charity work. The majority of their charity work was, in fact, compensated--below market value--but compensated nonetheless. Only a handful provided completely free care. If most of their "charity work" is Medicare and Medicaid, these physician clergy do not differ from secular physicians who, in 1996, derived 25-33% of their income from Medicare, 10-15% from Medicaid, and 42-43% from managed care.[74]

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[73]Komaromy, m., et. al., "California Physicians' Willingness to Care for the Poor," *The Western Journal of Medicine*, 1995; 162(2): 127-32.

[74]Gonzalez et. al., eds., p. 34.

Regarding the self assessment of time spent with patients, the results follow:

Time Spent with Patients

	more	less	about the same
Talking and getting to know patients:	67%(24/36)	none	33%(12/36)
Talking about spiritual factors of illness:	88%(28/36)	none	12%(4/32)

It is difficult to draw hard conclusions because there are neither controls nor objective ways of measuring how much time and energy is spent interacting with patients on human or spiritual levels. However, it is clear that, at least by their own self perception, these physician clergy consider human and spiritual interaction a clear priority in their practices.

7. Missions

The final question on the survey sought to determine how many of these physician clergy had ever served as missionaries. Forty-one percent (15/37) reported that they had spent time as a missionary in the past. The average time spent serving in missions was 4± 5 years ranging from two weeks to sixteen years. Of those who spent time working in missions, fully 50%(7/14) served in both their medical and ordained capacities. 36%(5/14) served only in their medical role, while a mere 14%(2/14) served only as an ordained clergy person.

Fewer people were involved in missions than expected, and many of them had served for such short periods of time that it was difficult to distinguish mission work from an unusual vacation. However, fully 41% reported some mission work, and this is probably much greater than the national average among physicians. Unfortunately, there is little data on the prevalence of missionary work among secular physicians. It would be interesting to know the rates among physicians of short-term medical mission or short-term volunteer service to developing countries.

D. Comparing Subgroups.

The preceding data were extracted from the entire population of respondents, but primarily from the 39 physician clergy who pursued both medicine and ministry. However, there were several distinct subgroups among the respondents. The following discussion concerns the differences and similarities between these subgroups.

1. Retired v. Not Retired

Of the 39 physician clergy who pursued both medicine and ministry, 13 were currently retired from at least one vocation whereas 26 were actively engaged in both vocations. As would be expected, the retired physician clergy were older than the non-retired cohort (73±8 v. 54±8 years). In both groups, there was a significant interim between ordination and medical school, but the retired cohort's interim was slightly longer (22±10 v. 16±10 years). Both groups had similar proportions of deacons and priests. Although the reasons are not obvious, it is striking that the distribution of medical disciplines was very different between groups: The retired group accounted for none of the internists or psychiatrists, but all five general surgeons and two of three obstetrician-gynecologists. The non-retired cohort included seven psychiatrists and four internists, but no surgeons.

Although the reasons for pursuing bivocational ministry were similar in both groups, the retired physician clergy appeared to integrate their vocations with less success and subtlety than the younger, non-retired cohort. For example, the retired cohort were more likely to segregate their two roles (27% v. 10%). They were also less likely to have served as rectors (0% v. 23%), but twice as likely to have served as chaplains (31% v.

12%). The retired cohort was also half as likely to have pursued academic careers (23% v. 42%).

It is not clear why the retired cohort was less well integrated, but perhaps it reflects recent changes in both medicine and ministry that facilitate bivocational ministry. For example, the retired cohort were seven times as likely to report institutional resistance to bivocational ministry (36% v. 5%) from either the church (9%) or medicine (27%).

Another possible explanation for the difference in integration may be that medicine was the dominant identity of the elder, retired cohort. When asked which vocation they would choose could they pursue only one, the retired cohort was ten times more likely to choose medicine (60% v. 6%), and only members of the retired cohort identified medicine as their "core identity"(44% v. 0%). Furthermore, the motivation for choosing medicine was different. The retired cohort was much less likely to identify financial reasons for choosing medicine over ministry (0% v. 25%).

A final possible explanation for the decreased integration may be that the retired cohort was less theologically sophisticated. For example, the retired group was more likely to either offer no theological justification or to misunderstand the questions about the relationship between the two vocations (33-38% v. 0-5%, questions 6,8,9,11). This difference in sophistication may be related to the observation that the retired cohort was half as likely to have started their careers in medicine (15% v. 30%).

Although the younger, non-retired cohort appeared to better integrate their two vocations, they were much more likely than the retired cohort to claim that there were significant tensions between the two vocations (90% v. 21%). However, this difference in perceived tension may be biased because the most frequently identified tension was "limited time" and retired persons tend to have more time at their disposal: Only 10% of the retired cohort identified limited time as a tension between vocations compared to 68% of the non-retired cohort. Along similar lines, when asked if bivocation had interfered

with their professional goals, 40% of the non-retired cohort stated that limited time was a factor whereas none of the retired cohort identified time as a factor interfering with their professional goals.

Perhaps the most striking difference between these two groups was their opinion on the right to die. Fully 83% of the retired cohort believed in a right to die whereas only 21% of the non-retired cohort shared this belief. It is particularly surprising that the younger group was significantly more conservative than the older group considering that "polls show that it is the young and healthy--not the old and sick, as is widely assumed--who clamor for the right to die."[75] However, this difference may be due to the fact that the retired cohort is either themselves closer to exercising this right to die or they are closer to friends at the end of life who would want to exercise this right.

Finally, during their medical career, the retired cohort earned slightly less money, dedicated less of their practice to the under-served and were less likely to state that they spent more time talking with their patients when compared to their secular colleagues. However, the retired contingent were much more likely to have served as missionaries (67% v. 28%). This missionary service was most commonly medical (57% v. 14%), and never purely ministry (0% v. 29%). Furthermore, although both groups showed a very wide range in the duration of missionary work, the retired group averaged 6.4 years of service compared to only 1.8 years of service in the non-retired group. Perhaps this reflects a greater commitment to mission in the older generation.

2. Deacons v Priests

Of the 39 physician clergy who pursued both medicine and ministry, 24 were priests, 14 were deacons and 1 was a seminarian studying to be a priest. The range of age

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[75]Shapiro, J., "Death on Trial: The case of Dr. Kevorkian obscures critical issues," *U.S. News and World Report*, April 25, 1994; 115(16): 31.

was similar between priests and deacons. However, the priests were slightly less likely to live in the Bible Belt (46% v. 64%), and they were more likely to be men (92% v. 79%). The patterns of medical practice were similar between priests and deacons except that priests were more likely to be general surgeons (17% v 7%) or to have pursued an academic career (56% v 21%). Both priests and deacons reported similar rates of malpractice litigation, and their compensation packages were roughly similar. In general, the deacons tended to skip over more questions than the priests, and when they did respond, they were more brief.

There was no appreciable difference of opinion between priests and deacons concerning health care delivery and the right to die. However, priests were more likely than deacons to take an active role in biomedical ethics in the community (65% v. 29%) or serve on an ethics committee (39% v. 21%). Although they shared similar support for the "right to die," deacons were slightly more likely to advocate physician assistance in exercising that right (36% v. 22%).

Deacons were more likely to practice medicine as a regular job which remained their primary focus and primary source of income. For example, deacons were more likely than priests to choose medicine as their primary vocation (77% v. 16%) whereas priests were more likely to choose ministry, stating it was their core identity (71% v. 0%). Deacons were also less likely to practice medicine without remuneration (0% v. 17%), but were more likely to provide ministry without financial compensation (21% v. 7%). Furthermore, deacons dedicated less of their medical practice to charity (13% v. 30%) or under-served populations (26% v. 47%). Finally, deacons were less likely to have spent time as missionaries (21% v. 55%), and when they did, it was not for long: The maximum time commitment for deacons was six months with an average of four months compared to a five *year* average for priests (maximum 16 years).

Although deacons reported a greater self-perception of integration (85% v. 77%), other data suggest that priests better integrated their two vocations, pursuing alternative

models of practice which reflected their bivocational ministry. For example, priests were more likely than deacons to have been called to both vocations simultaneously (28% v. 0%) or to start in ministry and add medicine at a later date (33% v. 7%). This focus on integrating the vocations may be reflected in the shorter average interim between ordination and medical school (15 v. 21 years). Furthermore, priests were more likely to expand their ministry beyond the parochial setting, ministering to hospital staff (31% v. 5%). They were also more likely to practice medicine without remuneration (17% v. 0%). Finally, priests reported a slightly greater emphasis on spending time getting to know their patients (71% v. 57%) and discussing spiritual factors of illness (90% v. 82%). Given this different emphasis on integrating the two vocations, it is striking that whereas none of the deacons reported any institutional resistance to their bivocational ministry, 29% of the priests did encounter resistance from the church (10%) or from medicine (19%).

3. Integrators v Non-integrators

As described previously, of the 52 total respondents, 75%(39) integrated their two vocations at least to the extent of actively pursuing both vocations at the same time. The remaining 25%(12) had left one vocation for the other, and had never attempted to practice both vocations at the same time. Of these 12, 92%(11) left medicine for ministry. These two groups of "integrators" and "non-integrators" were similar in age, sex, and geographical location. However, the integrating group was much more likely to have been called first to ministry and then to medicine (23% v. 8%), suggesting that those called first to ordained ministry were more likely to integrate their vocations. Ordination is considered a permanent, life changing event. It is therefore not surprising that fewer respondents left ordained ministry for medicine

On average, the non-integrators had been ordained for a shorter duration (9 v. 18 years) and had waited longer to add their second vocation (23 v. 18 years). This suggests that the non-integrators were more likely to be practicing their second vocation later in life as a distinct alternative to their first vocation.

The statistics suggest that the non-integrating physician clergy adopted a more standard career path within the church which emphasized full-time parochial ministry as paid priests. For example, the non-integrators were more likely to have served as rectors (50% v. 15%), and they were half as likely to be deacons (25% v. 50%). Furthermore, the non-integrators were more likely to have sought remuneration for their ministry (50% v. 18%). However, they also had a greater propensity for subsidizing their ordained ministry with the resources previously earned in medicine (27% v. 3%).

Although the patterns of medical practice were similar between these two groups, the integrators were more likely to practice medicine without remuneration (15% v. 0%), and the non-integrators were less likely to practice surgical disciplines (8% v. 23%).

Finally, although both integrators and non-integrators responded similarly to the question about the theoretical possibility of integrating both vocations, it is interesting to note that the non-integrators perceived different tensions between the two vocations. The most commonly identified tension in both groups was time, but 30% of the non-integrators mentioned "other" tensions compared to only three percent of the integrating group. Clearly, something convinced these physicians to leave medicine for ministry, but the motivation and the tension in each individual case was usually unique.

DISCUSSION

1. Summary

The results of this study both corroborate and expand the findings of the other two reported surveys of physician clergy. Although it is not a common career path, many more physician clergy than expected were identified. They were an extremely diverse group of intriguing people who defied simple categorization. Each physician cleric had followed a unique path on his or her own journey to bivocational ministry. Although each physician cleric knew of one or two other persons pursuing a similar combination of ministry and medicine, by and large they were unaware of each other's existence. Each person had forged a unique ministry in relative isolation. As a result, it appears that the variety of paths to bivocational ministry is limited only by the number of physician clergy pursuing this unusual combination.

Given this profound diversity, it is difficult to draw many summary conclusions. This challenge was articulated by The Rev. Elizabeth Nestor, M.D. in her unpublished 1988 study of 33 physician clergy in the United States. She concluded,

> "It is difficult to know how, or even if one ought, to sum these responses up. I was able in the course of this project to meet an interesting and idiosyncratic group of individuals. Their views are strong and quite diverse....I offered some opportunity for expression, but this group is engaged in making sense on their own out of two personally demanding professions. And they make that sense, as do most people, by living it out, not by philosophizing upon the challenge.
>
> My feeling is that they must have a great personal impact, but there is no way to measure that. Nor is there a way (given the great diversity of individuals, the markedly different beliefs they hold and paths they have followed) to predict what person might feel called to a similar undertaking. It may be that this paper will have some success in giving their stories...more of an audience, and that in that audience will be others who are interested in a similar choice. It [bivocational ministry] will always be....the answer that some few make to the problem which life sets for them, but it is not likely to be the answer for more than a few at one time."[76]

[76]Nestor, Elizabeth, "The Impact of Ordained Ministry on the Medical Profession," an unpublished report for a Smith-Kline Beckman Medical Perspectives Fellowship #SK30/88A, 1988.

Despite the diversity within the population of physician clergy, there were notable trends. For example, if all the physician clergy studied were gathered together in one room, the typical person would likely be male and in his late fifties. Although some would have begun their careers in ordained ministry, most would have started as physicians, adding ordained ministry at some later date nearly two decades after becoming a doctor. Their work in medicine would likely occupy the majority of their time, and their career paths would span every type of medical practice and specialty from psychiatry to surgery and from academic to administrative. Within the church, although some would be rectors, most would be assistants as either deacons or associate priests. Many would have been involved in mission to some greater or lesser extent during their careers. Most of the physician clergy would have attempted to integrate their two vocations to some extent. If this integration was not formal, the integration would exist at least within the mind and soul of the physician cleric. However, as Nestor observed, "the impact of this joining of careers is greater on the individuals involved than on the medical profession."[77] Many would express ways in which their medical vocation broadened their perspective on humanity, thereby making it easier for them as clergy to connect with lay people. As physicians, their theological background often enhanced their perspective in addressing issues of suffering, illness and death.

Given this composite portrait of the average physician cleric, it is striking how similar the findings of this study were when compared to both Elizabeth Nestor's unpublished study and to Keith Leiper's 1984 study of 68 physician clergy in the United Kingdom. For example, Leiper reported:

> "The typical medical clergyman is in his 50s, probably Anglican, and almost certainly married with children...He probably formed the intention of becoming a doctor quite early in life, at about the age of 15...He is most likely to have studied at a London medical school, [and] only five of the group entered theological college first and so entered medical school as ordained clergymen.
>
> After qualification, [they] followed a wide range of careers in medicine. A third had worked abroad, either as missionaries or as government medical officers. The

[77]Nestor, p. 2.

> group was roughly equally divided into those who combined the roles of doctor and minister and those who had relinquished the practice of medicine altogether...Nine doctors had taken retirement from their career in the United Kingdom and had subsequently been ordained.
>
> The average medicleric applied for training as a minister at about the age of 45, but there was a wide range...He received most encouragement in taking this step from friends already in the ordained ministry...Two doctors had been directly invited to assume the role of pastor to their congregations...The training [in theology] varied greatly. The older entrants had studied for a shorter time and in a less formal manner than the younger men....Only seven of the group had emerged with either a master's or a bachelor's degree in theology, and 20 said that they had no formal theological qualification.
>
> Those who still practised medicine clearly saw their medical work as an extension of their ministry...Having been a doctor was seen as a benefit by several medical clergy: "One has an insight into the whole person." "The doctor is less shockable."... Sometimes difficulties arose in the dual role: "Unless I'm careful I suffer from role confusion." And a final, and rather worldly, comment: "I got paid more as a part-time doctor than as a full-time priest." ... Perhaps being a doctor is quite a useful preparation for the life of the minister. I, for one, hope so."[78]

In summary, this study was successful in surveying and characterizing a fairly exhaustive sample of Episcopal physician clergy. In many ways, the results corroborated the results of similar previous studies. However, this report was more complete and detailed. Great care and effort were dedicated to refining the description of this sample of physician clergy, and the depth and breadth of their responses to specific questions were documented. The careers and ideas of the studied sample of physician clergy were fascinating. Those who responded to this survey were wise and often quite eloquent. It is hoped that this study will catalyze more dialogue between these unusual practitioners.

2. Unexpected Observations

There are two observations derived from this study that remain puzzling, if not even troubling. First, these physician clergy struggled to articulate reasons for their pursuit of two vocations. As discussed previously, most had considerble difficulty articulating an adequate theological justification for having become both physicians and

[78]Lieper, 1984, pp. 1748-1749.

clergy. (See question 6). Furthermore, respondents frequently failed to understand questions that probed the tensions at the interface between medicine and ministry. (See questions, 8, 9, 11). This suggests that these physician clergy have not yet resolved for themselves the dialectic between their dual vocations.

Second, it was surprisingly difficult to distinguish these physician clergy from their secular colleagues. Although it was assumed that the combination of ordained ministry with medicine would alter the structure and pattern of medical practice, few differences were observed. For example, following the predominant bias of the medical profession, only 11% of these physician clergy routinely addressed spiritual issues in their medical practices. (See question 14). They also articulated traditional and largely uncritical opinions about the physician-patient relationship as well as the epistemic relativism of modern culture. (See questions 13, 15). Finally, there was no discernible difference between these physician clergy and secular physicians concerning rates of compensation, malpractice litigation or *pro-bono* work. (See Results, section C).

It is not clear why these physician clergy were so similar to secular physicians or why they found it difficult to explain their call to bivocational ministry. However, these two general observations suggest that significant challenges remain to the complete integration of medicine and ministry. It is clearly not an easy thing to be an ordained physician. The remaining discussion investigates several of the challenges to the bivocational ministry of physician clergy.

3. Serving Two Masters?

Several of the physician clergy suggested that a good doctor could be a good priest or deacon even though the reverse is not true. However, it is not clear to what extent this assertion should be accepted. Both medicine and ministry are all-consuming vocations, and as such it is doubtful that one person could be excellent at both. Medicine clearly requires extensive technical training not shared by clergy; but in the same way, the clergy are educated and trained with their own areas of expertise. Many of these physician clergy never attended seminary, having learned theology from correspondence courses. Few patients would accept a physician trained by correspondence courses. Should our expectations of clergy be any different?

If physician clergy must satisfy the independent criteria for excellence specific to each vocation, it seems likely that one vocation would end up suffering. This fact can be observed within the study group. Again and again, these physician clergy identified limited time as the greatest tension between the two vocations. Those physician clergy who continued to practice medicine were often only peripherally involved in the parochial life of the church. Those physician clergy who chose to pursue traditional excellence in ministry abandoned their medical practices because they were unable to keep up with both their parish duties and the changes in medicine. Consequently, it may be appropriate to question the propriety of those physician clergy who practice both vocations, but give only minimal attention to one vocation.

However, this line of argument does not adequately account for the experience of these physician clergy. Although most were only peripherally involved in the parochial life of the church, many viewed themselves primarily as clergy. Although they may not have been able to articulate all the reasons for their dual ministry, many considered

ordination a profound, life-changing event that shaped their identity at a deeper level than their medical vocation. Furthermore, although the combination of medicine and ministry might appear to be an attempt to "serve two masters", fully 44% perceived their ministry as a unified whole. Bivocational ministry may not be two ministries. Rather, it may be a single unified vocation different from either medicine or ministry, but combining aspects of both. If this is true, bivocational physician clergy are engaged in a unique task which can only be evaluated on its own terms. Unfortunately, it is not clear what those terms might be.

4. The Challenge of Bivocational Ministry.

These observations demonstrate that the nature of bivocational ministry remains unclear. What is bivocational ministry, and why would anyone want to do it? Why should a physician be ordained? What can physician clergy do by virtue of their dual vocations that cannot be done by monovocational clergy or monovocational physicians? It was hoped that the responses to this survey would resolve some of these questions, thereby elucidating the theory and practice of bivocational ministry. However, the answers to these thorny questions remain unclear even after 52 physician clergy attempted to explain their own approach to bivocational ministry.

Bivocational ministry challenges the traditional definitions of ordained ministry. If an ordained minister is not exercising that ordination by administering the sacraments of Baptism and Eucharist within the life of a church, it is not clear how that person's life is sacramental. At the current time, it is virtually impossible to define sacramental ministry outside the parochial context. However, the ministry of most bivocational clergy occurs outside the parochial context, and therefore, it is hard to discuss what they do and how it might be sacramental.

For example, The Rev. Edward Hook, founder of the National Association of Self-Supporting Ministers, observes that when asked to describe their ministry, bivocational clergy of all types are constrained by existing language. They are forced to use "church talk" to define their ministry. Bivocational clergy preach, "assist at the altar," or lead discussion groups on an occasional basis. It is through these types of activities that bivocational clergy define their ordained ministry. However, this limited vocabulary betrays the true character of their ministry which transpires outside the parochial setting where they interface with their secular professions. The church has limited means to describe or even understand this kind of ministry. Hook notes that most bivocational clergy consistently express feelings of alienation and frustration because the church and its parochial clergy do not understand what they are trying to do in their bivocational ministry.[79]

The confusion is apparent even in the terminology used to identify clergy who also profess another vocation. In addition to "bivocational" clergy, there are three interchangeable terms for dual-career clergy, none of which is adequate. "Non-stipendiary" is problematic because it defines the concept with a negative, stating what it is not rather than describing what the concept actually is. Furthermore, it defines the vocation in terms of money, and this is both inaccurate and constraining. The Presbyterian Association of Tentmakers prefers the term "tent-making" because it is rooted in the scriptural example of St. Paul who supported his ministry by practicing his trade of making tents. Although this term is better than "non-stipendiary," it still falls short of an ideal because it fails to capture the potential for mutual influence between the two vocations. In "tent-making," the secular profession exists simply to make the ordained vocation possible, again focusing on financial considerations. The same

[79]Hook, Edward. Telephone conversation on 2/8/99.

criticism applies to "self-supporting" ministry which limits the role of the secular profession simply to financial support.

This study used the term "bivocational ministry" because it best accommodates the notion of mutual influence between the ordained and the secular vocations. However, it is still inadequate because it implies that there are, in fact, two vocations rather than a single integrated vocation. The most articulate physician-clergy respondents captured this aspect of their ministry by stating that they were clergy who exercised their single vocation to ordained ministry within the context of medicine.

Given this wide confusion over terminology and the absence of adequate language to describe bivocational ministry, it is perhaps less surprising that these physician clergy were not generally articulate about the theory and theology of their bivocational ministry. Instead, as Nestor observed, physician clergy made sense of what they do "as do most people, by living it out, not by philosophizing upon the challenge."[80] Nestor's point is well taken, and it may be that as practical people, physician clergy do not have the resources to articulate the theoretical basis for their bivocational ministry. However, even if bivocational clergy cannot "philosophize" on their work, such a theoretical basis is required because a significant number of physician clergy and other bivocational clergy already exist, and the number is likely growing. Bivocational ministry is increasingly heralded as an intriguing alternative model of ministry. However, the church does not yet have the language to understand bivocational clergy, and those individuals pursuing ordination as bivocational clergy often encounter resistance. Until bivocational clergy can adequately explain what it is that they do, the integrity of their ministry will remain suspect in the eyes of the church.

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[80]Nestor, p. 4.

5. Formation of Bivocational Ministry in Isolation from Community.

The final, and perhaps most difficult challenge to physician clergy struggling to form a coherent expression of bivocational ministry was their isolation from community. Each of these physician clergy were navigating uncharted waters in career development. The variety of career paths was practically unlimited. Most found their way in isolation from each other. There was little conversation or support either from other physician clergy, or from other bivocational clergy involved in law, business or education.

This isolation only magnifies the challenges of developing new language and theology for describing bivocational ministry. The isolation might also explain why these physician clergy are not appreciably different from secular physicians. Isolated from each other and immersed in the secular medical context, it is not surprising that physician clergy adopted the characteristics of those around them. They did not have a community to hold each other accountable to approaching medical practice in ways intentionally rooted in their identity as ordained clergy.

The problem of isolation is not unfamiliar to the clergy. By virtue of their ordination, clergy are separated from ordinary society. Clergy consistently struggle to maintain networks of support with other clergy with whom they can form and shape their ministries and their identities. However, because there are so few physician clergy, the problem of isolation is significantly more acute. Furthermore, the demanding schedule of bivocational ministry often works against good intentions to dialogue with other clergy. My own experience corroborates this challenge. Although I have had access to the names and addresses of many physician clergy, I have not yet made the time to contact them beyond this survey.

However, the successful formulation of a theology of bivocational ministry depends on creating community. To that end, physician clergy might profit from more extensive dialogue with each other as well as with other bivocational clergy. The conversation might be further enriched if all bivocational clergy entered more extensive and intentional conversations with the wider church. To facilitate this dialogue, a Web site is under construction which will administer a list-server designed to break the isolation of physician clergy and provide a forum for conversation about bivocational ministry. The Internet may provide the medium to initiate and establish a community of physician clergy. (See Appendix 4 for further information).

6. My Own Approach.

This last section presents the author's own approach to the challenges of bivocational ministry. The thoughts which follow are speculative and personal. Furthermore, parts of the argument appeal to technical, theological concepts which may be unfamiliar to the general reader. As such, this last section may appear out of place within the context of a medical school thesis. However, the primary audience for this study is other physician clergy, and consistent with the original goals of the project, the study is intended to stimulate dialogue between and about physician clergy and their bivocational ministry. The author hopes that the following expression of his own approach to bivocational ministry will serve as a catalyst for further conversation.

* * * * *

I do not have the solution to the challenging problem of bivocational ministry. My own approach is still developing. I have not found a complete or satisfying synthesis, and my ideas continue to change. However, in the spirit of community, I offer my thoughts as they currently exist.

I have never articulated my call to ordination as being lived out within the context of the parish. Although I will always be attached to a parish church in which I will preach, teach and lead worship, this will not be the primary venue for my ordained ministry. Instead, I have always perceived my call to be a priest within the context of the hospital. As other physician clergy have stated, I see myself as a priest who will exercise my ordained ministry within the context of medicine, both with my patients and with the colleagues and staff of the hospital.

With my patients, the challenges of confusing boundary issues will make it unlikely that I will function overtly as both priest and physician to the same person. However, because of my unique training, I will have different ears to hear the frequent questions of meaning and value that are part of physician-patient conversations, and I will be able to address these questions as the spiritual questions they really are. Furthermore, what interests me most about medicine is the privilege physicians have as they convey life-changing diagnoses. At that moment, the physician has an amazing opportunity to help the patient weave the diagnosis into the fabric of life in a meaningful way. It will take a lifetime to become skillful at this pastoral type of interaction.

Within the hospital, I hope to position myself as a sort of ambassador between the two institutions of hospital and church—institutions that deal with the same people and the same life crises, but speak totally different languages. Through my bivocational training, I am becoming "bilingual." I am not sure what the conversation should be between hospital and church, faith and medicine, but I am convinced that the conversation should be encouraged.

In fact, the conversation is already underway in the context of the recent explosion of interest in alternative and complementary health care. The interest is indicative of a deep hunger that is not being fed by the current practice of Western medicine. I am not certain alternative health care is feeding that hunger with "solid food," but there is little doubt that hunger exists. The precise nature of the hunger is

unclear, but common to most alternative health care systems is a philosophical framework through which a patient can make sense of what it means to be sick. I propose that the attraction of alternative health care is found less in its efficacy than in its facility with finding meaning in illness.

In its success and zeal for effectively treating disease, Western medicine has largely abdicated its role as the interpreter of illness. In times of crisis and illness, patients and their families turn to their physicians for guidance in making sense of suffering. We have come to believe that sickness and death would be preventable if only we knew enough science. As a result, the reality of sickness is all the more shocking when it breaks into our otherwise tidy lives. In the current era of increasingly complex medical technology, it is more important than ever that physicians should cultivate their skills at helping patients interpret their illness in meaningful ways. Part of my ambition is to help physicians refine their skills at addressing these issues of meaning and value with their patients, connecting each patient to whatever social, philosophical or spiritual resources can help break the isolation of sickness and suffering.

However, even given these aspirations, it might still be observed that I need not be ordained to achieve these goals. On first examination, this may be true. However, there is something powerful and persuasive about the witness of someone who is both physician and priest. For example, when at conferences addressing the interface between faith and medicine, diverse people come together to discuss the common subject. Each person addresses that subject from their own particular perspective as physician, nurse practitioner, chaplain or patient. In some sense, each operates outside the "interface" that the conferences seek to address. However, as an ordained physician, I will live at the intersection between faith and medicine. Consequently, by virtue of who I am and where I live my life, my perspective on issues at the intersection between faith and medicine carries intrinsic weight. If I were not both an ordained clergyman and a practicing

physician, my identity would not be inherently linked to the intersection between faith and medicine, and my perspective would not be the same.

In theological terms, this notion might be expressed as follows. Christians believe that through the Incarnation, God has entered completely into the human experience. Through the Incarnation, there is no aspect of human experience that is foreign to God. Wherever we go, God is there also, participating in both our joy and our suffering. From this central belief follows the conviction that God is equally present in the intensive care unit as in the church sanctuary. Unfortunately, like most spiritual truths, this is not always obvious. It is often easy to accept that there is an insurmountable barrier between faith and medical science, between the chaplain and the physician.

However, God has ordained sacraments as "outward and visible signs of inward and spiritual gifts." As such, the life of an ordained physician might be considered a sacrament. It is the outward and visible sign—the living conviction—that the apparent gulf between faith and medicine is, in fact, an illusion. Through the "sacramental" life of an ordained physician, Christ asserts the truth that through his Incarnation, he has drawn all things together to himself in perfect unity with himself and with the Triune Godhead. Through Christ, there is no division between faith and medicine. The chasm is filled, and the communication is perfected to the point of unity.

This sacramental approach to bivocational ministry is powerful, but it may not be completely orthodox because it stretches the traditional understanding of sacrament beyond the narrowly defined context of parochial life. Furthermore, this approach runs the risk of confusing the symbol with the truth signified by that symbol. That is to say, the sacramental life of an ordained physician is only a symbol of Christ; the ordained physician makes no claim to actually be Christ. However, although potentially unorthodox, this approach may point to ways of understanding the powerful witness and ministry of bivocational clergy.

I am unable to assess the "sacramental" validity of my own life as I attempt to live it out at the intersection of faith and medicine. However, in whatever small steps I take, my presence as both priest and physician may begin to make real this vision of the divine unity between faith and medicine as we move toward the fulfillment of creation when Christ will establish forever the unity we now only glimpse "though a glass dimly."

These are my goals and hopes as I start my career as both priest and physician. I know that these thoughts will change with time. I only hope that this study will serve to catalyze further conversation about this interesting, unique and important form of Christian ministry.

Appendix 1-Database

Included in this appendix is the raw data extracted from the questionnaire. It is arranged in three sections. The first section is the database form with all the data fields labeled with a key to the coding system. Following the database form are two databases with raw data. The first database contains all the data except for the last page of the survey. This data is included in the second and final database. For either database, basic statistical summaries are located at the base of each column. To understand the database and its code, it may be helpful to refer to the survey instrument included at the end of Appendix 2.

DATABASE FORM

DEMOGRAPHICS

Identifier: (1-52)
First Name:
Last Name:
Address:
City: **State**: **Zip**
Telephone:
Release: 1=true, 0=false. (Did the person release personal information?)
Results: 1=true, 0=false. (Did the person want copies of the results?)

Bible Belt: 1=true, 0=false. (Did the person live in the Bible Belt?)
Sex: 1=female, 0=male. (This was assumed from the name.)
Age: Calculated by subtracting 25 years from the earliest degree (M.D. or M.Div.), and then calculating the age.
First Voc: 1=med, 2=min, 3=both. (Which vocation came first?)

MDiv: (date)
Seminary:
MD: (date)
Med School:
Date Residency:

Duration MD: =97-MD
DurationOrdain: =97-Ordain
InterimDegree: =MDiv-MD
InterimOrdain: =MD-Ordain

MINISTRY

Order: p=priest; d=vocational deacon; s=seminarian.
Seminarian: (What type of ministry are you studying toward?)
Ordain: (date)

Past Experience

(All are true/false 0/1)

1rector:
2associate:
3deacon:
4chaplain:
5mission:
6spiritdirect:
7military:
8quit:
9retired
10other:
11supply

Currentmin: (What is your current ministry? Record 1-11 above or "s" for seminarian.)
MinStipe: 0=all non-stipe; 1=mix; 2=all-stipe. (Are you paid for your current ministry?)

MEDICINE

Stillpractice: (true/false: Do you still practice medicine.)
Dateretire: (The date of retirement from medicine.)
Yrs Practice: Calculated years of practice: If still practicing, =97-MD. If retired, =Dateretire-MD.

Past Experience

(All are true/false 0/1)

1Private:
2acad/clin: (clinical academic position)
3acad/res: (basic science academic position)
4group:
5HMO/Staff:
6Administration:
7Other
8missions:
9retired
10military

CurrentMed: (What is your current medical practice? Record 1-11 above or "s" for seminarian.)
MedStipe: 0=all non-stipe; 1=mix; 2=all-stipe. (Are you paid for your current medical practice?)

NARRATIVE QUESTIONS

Question 1-Do you pursue both vocations (1=both, 2=not both)

1bothself: (Did they check the "both" box?)
1bothpast: (Did they pursue both at some point in the past?)
1bothme: (Did their answers to other questions establish that they did both even though they didn't check the box.)

Question 2- Direction of career change: med to min or vice versa

2direction 1=med to min; 2=min to med
2integrate: (Did they approve of integration?)
1=approved integrating; 2=disaprove; 3=tried and failed to integrate; 4=tried and then quit integrating; 5=integrated in past (informal); 6=limited informal integration.

Question 3- How do your careers mutually influence each other?

3influence: 1=much positive influence; 2=much negative influence; 3=no influence; 4=little positive influence; 5=little negative influence; 6=influenced by teaching natural theology, 7=influenced by giving a wider view of humanity.

Question 5-How were you called to both vocations?

5reason: (The explanation of how they came to practice two vocations: 1=coversion; 2=deepening of faith, 3=looking for more out of career, 4=dissatisfied with first vocation, 5=both at the same time, 6=ministry was first call, but response was delayed, 7=chaplaincy led to medicine, 8=retired to ministry
5envision: (Could you envision your career path? True/false.)

Question 6-What is your theological foundation for bivocational ministry?

6theology: 1=none, 2=don't understand, 3=St Paul's many gifts, 4=heal body/soul, 5=baptism/priesthood of all believers

Question 7-Do you integrate both vocations?

7integrate: 1=integrate, 2=segregate, 3=contextual integration only, 4=internal integration only, 5=increasinly integrated

Question 8-How does your medicine inform your ministry?

8inform: 1=don't understand, 2=none (segregate), 3=open mind with deeper broader perspective, 4=natural theology, 5=know human limits.

Question 9-How does your ministry inform your medicine?

9inform: 1=don't understand, 2=none (segregate), 3=end of life/ethics/difficult issues, 4=greater awareness and skill with spiritual issues and holistic approaches.

Question 10-If you had to choose only one vocation which would it be?

10choose: 1=med, 2=min, 3=can't choose, 4=don't understand
10reason: 1=it came first, 2=financial, 3=what I'm best at, 4=my core identity

Question 11-What do you offer?

11offer: 1=nothing, 2=absolution/laying on of hands/sacerdotal, 3=attuned to spirit/life/suffering, 4=perspective from the pulpit, 5=breadth of background/perspective, 6=don't understand.

Question 12-Do you reveal your ordination to patients?

12reveal: 1=never, 2=leave clues, 3=reveal when asked/appropriate, 4=all the time, 5=wear clerical garb in hospital.

Question 14-How do you introduce God?

14introduce: 1=never, 2=leave clues, 3=reveal when asked/appropriate, 4=all the time, 5=wear clerical garb in hospital.

Question 16-Do you minister to staff?

16staff: 1=yes, 2=no, 3=on occasion, 4=never thought of it

Question 17-Do your colleagues know that you are ordained?

17know: 1=yes, 2=no, 3=only some friends/close colleagues

Question 18-Have you encountered resistance?

18resist: 1=no, 2=yes from medicine, 3=yes from church

Question 19-Have patients ever switched away from you?

19switch: 1=no, 2=they switch to me

Question 20-Has bivocational ministry interfered with career goals?

20goals: 1=no, 2=church advancement limited, 3=don't have enough time.

Question 21-How do you recharge?(true/false)

21family
21vacation
21ministry: (recharge through work as minister)
21reflective: (recharge through personal reflection/meditation)
21noclue: (didn't understand)
21hobby
21prayer

Question 22-What is your theological understanding of suffering?

22theology 1=didn't understand, 2=basic theodicy, 3=other

Question 23-Have finances influenced your career choices?

23finances: 1=no, 2=better off in medicine, 3=remained in medicine in order to support family, 4=medicine subsidizes ministry, 5=yes.

Question 24-What is your personal piety? (true/false)

24catholic (anglo-catholicism)
24daily office
24journalling
24retreat
24dailyprayer

Question 25-What tensions do you perceive between the two vocations?

25tension (primary tension) 1=none, 2=time, 3=emotional energy, 4=other
25tension2 (secondary tension) 1=none, 2=time, 3=emotional energy, 4=other

Question 26-Is integration possible?

26integrate: 1=yes, 2=yes, even though I can't, 3=yes, with reservations, 4=no, 5=yes, even though I don't.

LAST PAGE DATA

ETHICS

Do you take an active role in biomedical ethics:

1a 1=yes, 0=no
1reason (area of involvement) 1=church, 2=hospital, 3=general

Do you serve on a hospital ethics committee (true/false)

1b:

Are you satisfied with the current health care delivery system?

1c 1=satisfied, 0=unsatisfied

Do you believe in a constitutional right to die?

1d (true/false)

Should physicians assist?

1d2: 1=physician assisted, 0=no physician assist
caveat: (qualifications of answer) 1=PAS only under close regulation, 2=assist only if the physician chooses, 3=no euthanasia.

How should basic health care be provided?

1e1 (fee for service)
1e2 (fee for service with physician altruism)
1e3 (a guaranteed privilege of citizenship
1e4 (a guaranteed human right)
1e5 (other)

MALPRACTICE

How many times have you been sued for malpractice?

2A 1=never, 2=once, 3=2-5 times, 4=5-10 times, 5=more than 10

How many times have you been found negligent?

2B 1=never, 2=once, 3=2-5 times, 4=5-10 times, 5=more than 10

How many times have you settled out of court?

2C 1=never, 2=once, 3=2-5 times, 4=5-10 times, 5=more than 10

Compared to colleagues, your rate of malpractice is:

2D 1=greater, 2=lesser, 3=about the same

COMPENSATION

How many hours do you work each week?

3A (number)

What is your annual income?

3B 1=less than $75K, 2=$75-150K, 3=$150-250K, 4=more than $250.

Compared to colleagues, your rate of compensation is:

3D 1=greater, 2=lesser, 3=about the same

PATTERNS OF PRACTICE

What percent of practice do you dedicate to "charity?"

4A (number)

What percent of your practice treats the underserved population?

4B (number)

Compared with colleagues, the time I spend getting to know patients is?

4C 1=greater, 2=lesser, 3=about the same

Compared with colleagues, the time spent talking about spiritual factors is?

4D 1=greater, 2=lesser, 3=about the same

Have you ever been a missionary?

4E 1=yes, 0=no

If Yes, in what capacity

4E2 1=medicine, 2=ordained ministry, 3=both

If Yes, for how many years?

4E3 (number in years)

identifier	Bible Belt	Sex (0=male, 1=female)	Age	First Voc	MDiv	Seminary	MD	Med School	Date residency	DurationMD	DurationOrdain	InterimDegree	InterimOrdain	Order	Seminarian	Ordain	Type	1rector	2associate	3deacon
1	FALSE	0	51	2	71	roman catho	77	SUNY	81	20	26	6	6	1		71	1	FALSE	TRUE	FALSE
2	FALSE	0	49	2	73	cdsp	83	u of london	85	14	23	10	9	1		74	1	TRUE	TRUE	FALSE
3	FALSE	0	54	2	68	harvard	76	case westem	76	21	28	8	7	1		69	1	FALSE	FALSE	FALSE
4	FALSE	0	55	2	69	read	67	duke	73	30	27	2	3	1		70	1	TRUE	TRUE	FALSE
5	FALSE	0	42	2	80	nashota	92	am u of cambiea	98	5	17	12	12	1		80	1	TRUE	TRUE	TRUE
6	FALSE	1	43	3	79	eds	79	u of vt in boston	82	18	17	0	1	1		80	1	FALSE	TRUE	FALSE
7	FALSE	0	57	1	94	lutheran-phill	65	pitt	70	32	1	29	31	1		96	1	FALSE	TRUE	FALSE
9	TRUE	0	74	1	80	read	48	tennessee	49	49	16	32	33	1		81	0	FALSE	TRUE	FALSE
10	TRUE	0	54	1	81	read	68	unmc	75	29	12	13	17	1		85	1	TRUE	TRUE	FALSE
11	TRUE	0	49	1	78	read	73			24	18	5	6	1		79	1	FALSE	TRUE	FALSE
12	TRUE	0	39	1	89	quito	83	dominican rep	95	14	7	6	7	1		90	1	TRUE	FALSE	FALSE
13	FALSE	0	63	1	82	berkeley	59	comell	64	38	13	23	25	1		84	1	FALSE	TRUE	FALSE
14	TRUE	0	58	1	82	read	64	comell	67	33	14	18	19	1		83	0	TRUE	TRUE	FALSE
15	TRUE	0	49	1	98	etss	73	u texas-galvasto	78	24	1	25	25	3	p	98	1	FALSE	FALSE	FALSE
16	FALSE	0	68	1	70	cdsp	54	st louis u	62	43	20	16	23	1		77	1	FALSE	TRUE	FALSE
17	FALSE	0	81	2	41	wycliffe collg	50		58	47	55	9	8	1		42	1	FALSE	TRUE	FALSE
18	TRUE	0	79	1	69	read	43	duke		54	25	26	29	1		72	1	FALSE	TRUE	FALSE
19	TRUE	0	79	1	69	ETS	43	tulane	49	54	29	26	25	1		68	1	FALSE	FALSE	FALSE
20	TRUE	0	66	1	73	sewanee	56	med col of VA	61	41	24	17	17	1		73	1	FALSE	TRUE	FALSE
21	TRUE	0	72	1	65	read	50	u of kansas		47	32	15	15	2		65	1	FALSE	FALSE	TRUE
22	TRUE	1	77	1	56	read	45	u of TN	49	52	41	11	11	2		56	1	FALSE	FALSE	TRUE
23	TRUE	0	69	1	86	read	53	kansas u	58	44	11	33	33	2		86	1	FALSE	FALSE	TRUE
25	FALSE	0	49	2	73	ets	78	case westem	81	19	24	5	5	2		73	1	FALSE	FALSE	TRUE
27	TRUE	1	75	1	66	read	47	syracuse	59	50	31	19	19	2		66	1	FALSE	FALSE	TRUE
28	FALSE	1	60	1	83	read	62	edinborough	67	35	14	21	21	2		83	1	FALSE	FALSE	TRUE
29	TRUE	0	58	1	88	read	84		70	33	11	22	22	2		86	1	FALSE	FALSE	TRUE
30	TRUE	0	50	1	85	Sewanee-ex	72	Oklahoma	78	25	12	13	13	2		85	1	FALSE	FALSE	TRUE
32	TRUE	0	60	1	75	read	62			35	22	13	13	2		75		FALSE	FALSE	TRUE
33	FALSE	0	50	1	89	read	72	u of pitt	77	25	8	17	17	2		89	1	FALSE	FALSE	TRUE
34	FALSE	0	66	1	76	read	58	U Dub	62	41	21	20	20	2		76	1	FALSE	FALSE	TRUE
34	TRUE	0	60	1	98	read	62	u texas, southwe	67	35	1	34	34	2		96	1	FALSE	FALSE	TRUE
35	TRUE	1	52	1	95	etss	70	u of Miss	72	27	2	25	25	1		95	1	FALSE	FALSE	FALSE
36	FALSE	0	60	1	89	Nashota	62	Western reserve	64	35	8	27	27	1		89	1	TRUE	FALSE	FALSE
37	TRUE	0	44	1	95	nashota	78	u of kansas	81	19	2	17	17	1		95	1	FALSE	TRUE	FALSE
38	TRUE	0	48	1	97	sewanee	74	u of guadalahara	78	23	0	23	23	3	p	97	1	TRUE	FALSE	FALSE
40	FALSE	0	62	1	97	cdsp	60	loma linda	69	37	0	37	37	1		97	1	FALSE	TRUE	FALSE
41	TRUE	0	44	1	91	general	78	u of miss	81	19	6	13	13	1		91	1	TRUE	FALSE	FALSE
42	TRUE	1	46	1	93	VTS	76	u of Tenn	81	21	3	17	18	1		94	1	FALSE	TRUE	FALSE
43	FALSE	0	38	1	94	tesm	84	U of FL	87	13	3	10	10	1		94	1	TRUE	FALSE	FALSE
44	TRUE	0	73	1	56	Berkeley	49	LSU	53	48	41	7	7	1		56	1	TRUE	FALSE	FALSE
45	FALSE	0	68	1	86	read	54	Columbia	60	43	4	32	39	1		93	1	FALSE	TRUE	TRUE
46	FALSE	0	64	1	95	read-sewane	58	ucsf	60	39	2	37	37	2		95	1	FALSE	FALSE	TRUE
47	FALSE	0	65	1	93	read	57	u of Michigan	63	40	4	36	36	2		93	1	FALSE	FALSE	TRUE
48	TRUE	0	58	1	95	read	64	dentist	67	33	1	31	32	2		96	1	FALSE	FALSE	TRUE
49	TRUE	1	47	2	75	?	83	?	85	14	20	8	6	1		77	1	FALSE	TRUE	FALSE
50	FALSE	0	70	2	52	VTS	64	george washingt	67	33	45	12	12	1		52		TRUE	TRUE	FALSE
52	FALSE	0	57	2	65	cdsp	72	case westem	77	25	30	7	5	1		67	1	FALSE	TRUE	FALSE

COUNT:	SUM:	Female:	AVG:	med:	AVG:	AVG:	AVG:	AVG:	Priest:									SUM:	SUM:	SUM:
47	25	7	58 6	36	31.9	18 4	18 0	18 5	30									12	22	17
	COUNT:	%:	MIN:	min.	MIN:	MIN:	MIN:	MIN:	Deacon:									COUNT:	COUNT:	COUNT:
	47	15%	38	10	5 0	0 0	0 0	1 0	15									47	47	47
	%:	Male:	MAX:	both:	MAX:	MAX:	MAX:	MAX:	Seminarian									%:	%:	%:
	53%	40	81	1	54 0	55 0	37 0	39 0	2									26%	47%	36%
		%	STD:		STD:	STD:	STD:	STD:												
		85%	11 3		12.2	13 2	10.0	10 4												

4chaplain	5mission	6spiritdirect	7military	8quit	10Other	11supply	Currentmin	MinStipe	Specialty	stillpractice	Yrs Practice	Specialty2	dateretire	1Private	2acad/clin	3acad/res	4group	5HMO/Staff	6Administration	7other
FALSE	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE	2	0	2	TRUE	20			FALSE	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE
TRUE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	2	0	2	TRUE	14			FALSE	TRUE	TRUE	FALSE	FALSE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	TRUE	FALSE	10	0	1	TRUE	21			FALSE	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	1		9	TRUE	30			FALSE	TRUE	TRUE	FALSE	FALSE	FALSE	FALSE
TRUE	FALSE	FALSE	FALSE	FALSE	TRUE	TRUE	11	0	1	TRUE	5			FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	TRUE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	TRUE	2	0	3	TRUE	18			TRUE	TRUE	FALSE	TRUE	TRUE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	2		7	TRUE	32			FALSE	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	TRUE	11	1	3	TRUE	49			TRUE	FALSE	FALSE	TRUE	FALSE	TRUE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	TRUE	2	1	12	TRUE	29			TRUE	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	2	0	4	TRUE	24	1		TRUE	FALSE	FALSE	FALSE	TRUE	FALSE	FALSE
FALSE	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE	1	1	1	TRUE	2			FALSE	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	TRUE	11	0	1	TRUE	38			TRUE	FALSE	FALSE	FALSE	TRUE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	TRUE	FALSE	2	0	4	TRUE	33			TRUE	TRUE	FALSE	TRUE	FALSE	FALSE	TRUE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE			5	TRUE	24			TRUE	FALSE	FALSE	TRUE	FALSE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	2		9	TRUE	43		92	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
TRUE	TRUE	FALSE	FALSE	FALSE	FALSE	TRUE	10		8	TRUE	47		92	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	9	0	8	TRUE	54	10	90	TRUE	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE
TRUE	FALSE	FALSE	FALSE	FALSE	FALSE	TRUE	9	0	8	TRUE	54	2	84	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	2		11	TRUE	41		95	TRUE	TRUE	FALSE	TRUE	FALSE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	9		3	TRUE	47		95	TRUE	FALSE	FALSE	TRUE	FALSE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	3	0	4	TRUE	52	1	93	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	3	0	8	TRUE	44	2	92	TRUE	FALSE	FALSE	TRUE	FALSE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	3	0	2	TRUE	19			FALSE	TRUE	FALSE	FALSE	FALSE	FALSE	TRUE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	3	0	11	TRUE	50	3	85	TRUE	TRUE	TRUE	FALSE	FALSE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	3	0	1	TRUE	35			TRUE	FALSE	FALSE	FALSE	TRUE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	3	0	2	TRUE	33	15		TRUE	FALSE	FALSE	TRUE	FALSE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	3	0	3	TRUE	25			FALSE	FALSE	FALSE	TRUE	FALSE	FALSE	FALSE
FALSE	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE	3	1	3	TRUE	35			TRUE	FALSE	FALSE	TRUE	TRUE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	3	0	8	TRUE	25			FALSE	TRUE	FALSE	FALSE	TRUE	TRUE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	TRUE	FALSE	3	0	13	TRUE	41			TRUE	FALSE	FALSE	TRUE	FALSE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	3	0	1	TRUE	35			TRUE	FALSE	FALSE	FALSE	FALSE	TRUE	FALSE
TRUE	FALSE	TRUE	FALSE	FALSE	FALSE	FALSE	3	2	1	TRUE	27		80	TRUE	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	1	0	16	TRUE	35		88	FALSE	FALSE	FALSE	FALSE	TRUE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	2		4	TRUE	19			FALSE	FALSE	FALSE	TRUE	FALSE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	seminanan		2	TRUE	23		94	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	TRUE	FALSE	2		14	TRUE	37	4	94	FALSE	TRUE	TRUE	FALSE	FALSE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	1	2	15	TRUE	19		87	FALSE	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	2	2	4	TRUE	21	18	90	TRUE	FALSE	FALSE	FALSE	TRUE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	1	2	3	TRUE	13		91	FALSE	FALSE	FALSE	TRUE	FALSE	FALSE	FALSE
TRUE	FALSE	FALSE	FALSE	FALSE	FALSE	TRUE	9	2	2	TRUE	48		53	FALSE	FALSE	FALSE	TRUE	FALSE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	2	0	8	TRUE	43	18	93	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
TRUE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	4	0	11	TRUE	39		92	TRUE	FALSE	FALSE	TRUE	FALSE	FALSE	FALSE
TRUE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	3	2	9	TRUE	40		95	TRUE	FALSE	FALSE	FALSE	TRUE	FALSE	FALSE
TRUE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	3	0	19	TRUE	33		80	TRUE	TRUE	TRUE	FALSE	FALSE	FALSE	FALSE
TRUE	FALSE	FALSE	FALSE	FALSE	TRUE	FALSE	10	1	20	TRUE	14			TRUE	FALSE	FALSE	TRUE	FALSE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	9	2	1	TRUE	33		95	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
FALSE	FALSE	FALSE	FALSE	FALSE	TRUE	FALSE	9	1	11	TRUE	25		79	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE

SUM:	SUM:	SUM:	SUM:	SUM:	SUM:	SUM:
10	4	1	0	0	7	8
COUNT:	COUNT:	COUNT:	COUNT:	COUNT:	COUNT:	COUNT:
47	47	47	47	47	47	47
%:	%:	%:	%:	%:	%:	
21%	9%	2%	0%	0%	15%	17%

5 nonstipe:	
13	34
14 mix:	
1	6
0 stipe:	
0	7
0	
0	
6	
3	
3	

8 SUM:	AVG:	
6	47	31 7
8 COUNT:	MIN:	
5	47	2 0
1 %:	MAX:	
1	100%	54 0
1	STD:	
5		12 7
3		
0		
4		
1		
1		
1		
1		
0		
0		
1		
1		

SUM:	SUM:	SUM:	SUM:	SUM:	SUM:	SUM:
31	18	5	16	9	3	3
COUNT:	COUNT:	COUNT:	COUNT:	COUNT:	COUNT:	COUNT:
47	47	47	47	47	47	47
%:	%:	%:	%:	%:	%:	
66%	38%	11%	34%	19%	8%	8%

8missions	10military	CurrentMed	MedStipe	1bothself	1bothpast	1bothme	2direction	2reason	2integrate	3influence	5reason	6theology	7integrate	8inform	9inform	10choose	10reason	11offer	12reveal	14introduce	16staff
TRUE	FALSE	2	2	TRUE	TRUE	TRUE					7	5	1	5		2	4	6	3	3	1
FALSE	FALSE	2	2	TRUE	TRUE	TRUE			1		7	4	1	3	5	3	4	5	3	1	3
FALSE	FALSE	2	2	TRUE	TRUE	TRUE					3	6	5	2	4			6	4	3	3
FALSE	FALSE	2	2	TRUE	TRUE	TRUE					5	4	1	3	4	2		6	3	3	1
FALSE	FALSE	7	2	TRUE	TRUE	TRUE					5	3	3	4	4	2	4	3	3	3	3
FALSE	FALSE	2	2	TRUE	TRUE	TRUE					5	4	4	4	5	3	4	3	3	3	3
FALSE	FALSE	1	2	TRUE	TRUE	TRUE					6	6	2	3	3	2	4	3	3	3	3
FALSE	FALSE	6	2	TRUE	TRUE	TRUE					2	7	3	4	4	1	1	5	3	3	3
FALSE	FALSE	1	2	TRUE	TRUE	TRUE					2	7	1			3	4	2	5	3	1
FALSE	FALSE	5	2	TRUE	TRUE	TRUE					6	7	3	3	4	3	4		3	3	3
TRUE	FALSE	2	2	TRUE	TRUE	TRUE					5	4	1	3	4	2	4	3	3	3	3
FALSE	FALSE	5	2	TRUE	TRUE	TRUE					3	7	1		4	3	4	3	5	3	3
FALSE	FALSE	2	2	TRUE	TRUE	TRUE					2	5	1	5	4	2	4	5	4	3	1
FALSE	FALSE	1	2	TRUE	TRUE	TRUE					6	3	1	5	4	1	3	3		3	
FALSE	FALSE	9		TRUE	TRUE	TRUE					3	1	1	4	4	1	1	7	4	1	3
FALSE	FALSE	7		TRUE	TRUE	TRUE					5		1	1	1	2	1	5	3	3	3
FALSE	FALSE	9	2	TRUE	TRUE	TRUE								4						3	3
FALSE	FALSE	9	1	FALSE	TRUE	TRUE					3	7	2	3	4	3		5	1	2	3
FALSE	FALSE	9	2		TRUE	TRUE					2	1	2	2	4	3			1		3
FALSE	FALSE	9	2	FALSE	TRUE	TRUE					3		1								
FALSE	FALSE	9	2		TRUE	TRUE						7	3			1	3	3	3	2	3
FALSE	FALSE	7	2	TRUE	TRUE	TRUE					2	7	1	1	1	1	1	1	4	3	1
FALSE	FALSE	2	2	TRUE	TRUE	TRUE					7	4	5	3	4	1	2	6	3	4	2
FALSE	FALSE	9	2	TRUE	TRUE	TRUE					2	1	2	1	1	1		3	5	3	1
FALSE	FALSE	5	2	TRUE	TRUE	TRUE					3	8	1	3	4	3		5	3	4	1
FALSE	FALSE	1	2	TRUE	TRUE	TRUE					2	1	4	3	2	1	2	1	3	3	2
FALSE	FALSE	4	2	TRUE	TRUE	TRUE					1		1	3	4	1	2	3	3	3	3
TRUE	FALSE	7	1	TRUE	TRUE	TRUE					1	4	5	3	4	1		2	2	1	3
FALSE	FALSE	6	2	TRUE	TRUE	TRUE					6	3	1	3	4	3		4	3	4	1
FALSE	FALSE	1	2	TRUE	TRUE	TRUE					6	7	4	2	2	1	3	5	1	2	2
FALSE	FALSE	1	2	TRUE	TRUE	TRUE					3	7	2	2	2	1	2	3	1	1	1
FALSE	FALSE	9	2	FALSE	FALSE	FALSE	1	3	5	1		7	4	3		2	4	5			1
FALSE	TRUE	9	2	FALSE	FALSE	FALSE	1	8	6	4			2	2		2		5	2	4	3
TRUE	FALSE	6	0	FALSE	FALSE	TRUE	1														
FALSE	FALSE	9	2	FALSE	FALSE	FALSE	1		1	7											
FALSE	FALSE	9	2	FALSE	FALSE	FALSE	1	8	6	7											
FALSE	FALSE	9	2	FALSE	FALSE	FALSE	1						2								
FALSE	FALSE	9	2	FALSE	FALSE	FALSE	1		2	4			2								
FALSE	FALSE	9	2	FALSE	FALSE	FALSE	1	2		1		4	4								
FALSE	FALSE	9	2	FALSE	FALSE	FALSE	1	6	6	1		4	4	3	4					3	1
TRUE	FALSE	9	2	FALSE	TRUE	TRUE	1	8	5	4		4	3							3	
FALSE	FALSE	9	2	FALSE	FALSE	FALSE	1	6	6	1		4	4	3	2	3		3		3	1
FALSE	TRUE	9	2	FALSE	TRUE	TRUE	1	3	1	1		4	1	3	3	2	5	1	3	3	3
FALSE	FALSE	9	2	FALSE	FALSE	FALSE	1		6	4											
FALSE	FALSE	4	2	FALSE	FALSE	TRUE	2		6	1		7	4	3	4	3		3	1	3	3
FALSE	FALSE	9	2	FALSE	TRUE	FALSE	2		3	4		4	4						3	3	3
FALSE	FALSE	9	2	FALSE	TRUE	TRUE	2		6	1		7	4	3	4	2		1	3	2	1

SUM: SUM:
5 2
COUNT: COUNT:
47 47
%: %:
11% 4%

6 nonstipe: SUM: SUM: SUM:
6 3 27 35 36 med to min
0 mix COUNT: COUNT: COUNT: 14
2 2 45 47 47 min to med
3 stipe: %: %: %: 3
2 42 60% 74% 77% totei
4 17
1
21

	reason	integrate	influence	reason	6theology	7integrate	8inform	9inform	10choose	10reason	11offer	12reveal	14introduce	16staff
	0	3	7	0	0	2	0	0	0	0	2	2	0	4
	1	1	0	0	0	4	1	1	4	0	0	1	2	0
	2	1	0	2	0	1	7	1	3	0	2	3	6	5
	0	0	5	0	6	7	0	4	0	1	0	0	1	0
	0	2	0	0	0	0	0	0	0	1	3	0	0	0
	1	7	0	0	0	0	0	0	0	0	0	0	0	0
	0	0	3	0	4	0	0	0	0	0	0	0	0	0
	5	0	0	0	0	0	0	0	0	0	0	0	0	0
	response	response	response	response	response	response	response	response	response	response	response	response	response	response
	9	14	15	2	10	14	8	6	7	2	7	6	9	9
	0%	21%	47%	0%	0%	14%	0%	0%	0%	0%	29%	33%	0%	44%
	11%	7%	0%	0%	0%	29%	13%	17%	57%	0%	0%	17%	22%	0%
	22%	7%	0%	100%	0%	7%	68%	17%	43%	0%	29%	50%	67%	56%
	0%	0%	33%	0%	60%	50%	0%	67%	0%	50%	0%	0%	11%	0%
	0%	14%	0%	0%	0%	0%	0%	0%	0%	50%	43%	0%	0%	0%
	11%	50%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	0%	0%	20%	0%	40%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	56%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

17know	18resist	19switch	20goals	22theology	23finences	25tension	25tension2	26integrate	5envision	21Family	21vacation	21ministry	21reifective	21hobby	21prayer	21noclue	24catholic	24daily office	24journalling
1	1	1	2	2	1	2	3	1	FALSE	TRUE	TRUE	FALSE	FALSE	TRUE	TRUE	FALSE	FALSE	TRUE	FALSE
1	1	1	1		2	2		4	FALSE	TRUE	FALSE	FALSE	FALSE	FALSE	TRUE	FALSE	FALSE	FALSE	FALSE
1	1	2	1		3	2	4	1	FALSE	TRUE	FALSE	FALSE	FALSE	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE
1	1	1	1	2	1	2		1	FALSE	FALSE	FALSE	FALSE	FALSE	TRUE	TRUE	TRUE	FALSE	FALSE	FALSE
1	3	1		2	1	1		1	FALSE	FALSE	TRUE	FALSE	TRUE	TRUE	TRUE	FALSE	TRUE	TRUE	TRUE
3	1	1	2	2	1	2		1	FALSE	TRUE	TRUE	FALSE	TRUE	TRUE	TRUE	FALSE	FALSE	TRUE	FALSE
2	1	1	1	2	1				FALSE	FALSE	TRUE	FALSE	FALSE	FALSE	FALSE	TRUE	FALSE	TRUE	FALSE
1	1	1	1	3	1	2		1	FALSE	TRUE	TRUE	FALSE	FALSE	TRUE	TRUE	FALSE	FALSE	FALSE	FALSE
1	1	1	1	2	1	1		1	FALSE	FALSE	FALSE	TRUE	FALSE	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE
3		1	1	3	1	3		1	FALSE	FALSE	FALSE	FALSE	TRUE	FALSE	TRUE	FALSE	FALSE	FALSE	FALSE
1	2	1	3	2	1	2	4	3	FALSE	FALSE	TRUE	FALSE	FALSE	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE
1	1	1	1	3	2			1	FALSE	FALSE	FALSE	FALSE	TRUE	TRUE	TRUE	FALSE	FALSE	TRUE	FALSE
1	1	2	1	3	1	2	3	1	FALSE	FALSE	FALSE	FALSE	TRUE	TRUE	TRUE	FALSE	FALSE	FALSE	FALSE
3	1	1	1	3	1	2		1	FALSE	TRUE	FALSE	FALSE	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
1	2	1	1	3	1	1		1	FALSE	FALSE	FALSE	FALSE	FALSE	TRUE	FALSE	TRUE	TRUE	FALSE	FALSE
1	2	1	1	3	1	1		1	FALSE	TRUE	FALSE	FALSE	TRUE	FALSE	TRUE	FALSE	FALSE	TRUE	FALSE
1	1	1	1	3	1	1		1	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	TRUE	FALSE	FALSE	FALSE	FALSE
3	1	1	1	2	1	2		3	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	TRUE	FALSE	TRUE	FALSE
1	2	1	2		3	1	4	2	FALSE	FALSE	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
					1	1		1	FALSE	TRUE	FALSE	FALSE	FALSE	TRUE	TRUE	FALSE	FALSE	FALSE	FALSE
1	1	1	1	2	3	1		3	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	TRUE	FALSE	FALSE	FALSE
1	1	1	1	2	1	1		1	FALSE	FALSE	TRUE	TRUE	TRUE	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE
3	1	1	3	3	3	2		3	FALSE	TRUE	TRUE	FALSE	TRUE	TRUE	TRUE	FALSE	FALSE	FALSE	FALSE
1	1	1	1	1	1	1		4	FALSE	FALSE	FALSE	TRUE	TRUE	FALSE	TRUE	FALSE	FALSE	TRUE	FALSE
3	1	1	3	2	3	2		1	FALSE	TRUE	TRUE	FALSE	TRUE	TRUE	TRUE	FALSE	FALSE	FALSE	FALSE
3	1	1	3	2	1	2		4	FALSE	TRUE	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	TRUE	FALSE
1	1	2	3	2	3	2	4	3	FALSE	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
1	1	1	1	2	1	4		1	FALSE	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	TRUE	FALSE
1	1	1	1	2	1	2		1	FALSE	TRUE	TRUE	FALSE	FALSE	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE
3	1	1	3	3	1	1		1	FALSE	FALSE	FALSE	FALSE	FALSE	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE
1	1	2	3	3	3	2		1	FALSE	TRUE	TRUE	FALSE	TRUE	TRUE	FALSE	FALSE	FALSE	FALSE	FALSE
						4		5	FALSE	TRUE	FALSE	FALSE	FALSE	TRUE	TRUE	FALSE	FALSE	FALSE	FALSE
1	1			3	4	2		2	FALSE	TRUE	FALSE	FALSE	FALSE	TRUE	TRUE	FALSE	TRUE	TRUE	FALSE
						1		3	FALSE	TRUE	FALSE	FALSE	FALSE	TRUE	TRUE	FALSE	TRUE	TRUE	FALSE
					1	1		5	FALSE	TRUE	FALSE	FALSE	FALSE	TRUE	TRUE	FALSE	FALSE	TRUE	FALSE
1				2	5	4		3	FALSE	TRUE	FALSE	FALSE	FALSE	TRUE	TRUE	FALSE	TRUE	FALSE	FALSE
					1				FALSE	TRUE	FALSE	FALSE	FALSE	TRUE	TRUE	FALSE	FALSE	FALSE	FALSE
				2	2	2	3	4	FALSE	TRUE	FALSE	FALSE	FALSE	TRUE	TRUE	FALSE	FALSE	TRUE	FALSE
					1				FALSE	TRUE	FALSE	FALSE	FALSE	TRUE	TRUE	FALSE	FALSE	FALSE	FALSE
1	1			2	1	1	2	5	FALSE	TRUE	FALSE	FALSE	TRUE	FALSE	TRUE	FALSE	FALSE	TRUE	FALSE
1				2					FALSE	TRUE	FALSE	FALSE	FALSE	TRUE	TRUE	FALSE	FALSE	FALSE	FALSE
					1	1		5	FALSE	TRUE	TRUE	FALSE	FALSE	TRUE	TRUE	FALSE	FALSE	FALSE	TRUE
1	1	1	1	2	4	1	2	3	FALSE	FALSE	FALSE	FALSE	FALSE	TRUE	TRUE	FALSE	FALSE	FALSE	FALSE
					4	1			FALSE	TRUE	FALSE	FALSE	FALSE	TRUE	TRUE	FALSE	TRUE	TRUE	FALSE
1	1	1	3	3	2	2		1	FALSE	TRUE	FALSE	FALSE	FALSE	TRUE	TRUE	FALSE	FALSE	FALSE	FALSE
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1	3	1	2	2				2	FALSE	TRUE	FALSE	FALSE	FALSE	TRUE	TRUE	FALSE	FALSE	FALSE	TRUE

17know	18resist	19switch	20goals	22theo	23finence	25tension	25tensio2	26integrete
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0	0	0	1	7	2	4	2	3
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0	0	0	0	0	4	3	0	1
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0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0
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0%	0%	0%	0%	0%	0%	0%	0%	0%

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47	47
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38	1	2	1	0	2	1	1	3	24	
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50	0		0	1		1	0		12	1
51	0		0	0	2	1	1		4	
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last page all data

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		52%			53%			13%		
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					2	1	2	2	40	2	2
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					1	1	1	2	60	2	2
			1		1	1	1		45	2	2
			1			1	1	3	40	2	3
					1	1	1	2	40	4	2
			1		1	3	3	3	50	2	3
		1			1	1	1		40	1	2
1			1		3	1	2	3	55	2	2
1					2	1	1	2	30	1	2
			1		2	1	1	2	65	4	3
					2	1	2	3			
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1					2	1	1	3	95	3	2
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					1						
			1		1	1	1	2	60	2	3
				1	1	1	1	2	44	2	3
1					3	1	1	3	50	2	2
1			1		1	1	1	2	38	3	1
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1					2	1	1	2	70	2	3
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					1	1	1				
			1		1	1	1	3			3
1					1	1	1	2		1	2
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1		1			2	1	2	2	60	4	1
			1		3	1	1	2	55	2	2
			1		1	1	1			1	
				1	1	1	1		30	2	3
			1		1	1	1	3			
1					1	1	1				
1		1	1		3	1	1	2		2	2
1					3	1	3	2		4	1
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					1	1	1	2	40	3	1
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			1							2	1
1					1	1	1	2			

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				8	1	4	14	16	9	21
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				59%	96%	78%	0%	STD	16%	14%
				24%	2%	14%	64%	16.3	51%	37%
				16%	2%	8%	33%		21%	49%
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5	20	1	1	0		
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		1		0		
30	30	3	1	1	2	5
	10	1	1	0		
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		1	1	1	3	10
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40	90	1	1	1	1	16
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		3	3	0		
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15	20	3	3	1	1	0.5
0	50	1	1	0		
15	20	1	1	0		
				0		
20	10	1		0		
	100	1	1	0		
10	1	3	1	0		
11	2	3	1	0		
25	15	1	1	0		
20		1	1	1	3	0.25
8	8	1	1	1	3	0.04
		1		0		
				0		
		1	3	1	2	0.12
100	99	3	3	1	3	4
5	0	1	1	0		
8	8	1	3	0		
30		1	1	0		
				0		
		1	3	0		
				0		
				0		
		1	1	1	1	8
25	15	1	1	0		
17	60	3	1	0		
				1	1	
15		1	1	0		
				0		
				0		
	0	1	1	0		

4A	4B	4C	4D	4E	4E2	4E3
Count:	Count:	Count:	Count:	Count:	Count:	Count:
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52%	56%	81%	73%	100%	31%	27%
Average:	Average:	Tabulate:	Tabulate:	Total YES	Tabulate:	Average:
21.1	34.9	30	31	17	6	3.7
Minimum:	Minimum:	0	0	% YES:	3	Minimum:
0	0	12	7	33%	7	0.04
Maximum:	Maximum:	0	0		0	Maximum:
100	100	%Tab:	%Tab		%Tab:	16
STD:	STD:	71%	82%		38%	STD:
21.3	36.5	0%	0%		19%	4.8
		29%	18%		44%	
		0%	0%		0%	

Appendix 2-Instruments

This appendix includes: 1)Search strategy for Medline search; 2)Documentation of proposals to the Human Investigations Committee; 3)Samples of the survey instruments.

MEDLINE SEARCH STRATEGY FOR PHYSICIAN CLERGY

Database: Medline <1966 to present>

Set	Search	Results
1	exp physicians/	28883
2	exp clergy/	458
3	1 and 2	26
4	priest.tw	94
5	physician.tw	40464
6	4 and 5	16
7	doctor.tw	10151
8	4 and 7	9
9	6 or 8	23
10	from 9 keep 1,4,6,8,11,14,16,18-23	13
11	1 and 4	7
12	11 not 9	4
13	from 12 keep 3-4	2
14	from 3 keep 1,7,11,15,24	5
15	clergy.tw	206
16	10 or 13 or 14	20
17	minister.tw	507
18	pastor.tw	38
19	1 or 5 or 7	71843
20	17 and 19	24
21	18 and 19	8
22	from 21 keep 2,6-8	4
23	15 and 19	33
24	from 23 keep 10	1
25	exp alled health personnel/	21449
26	15 or 17 or 18	749
27	25 and 26	5
28	exp nurses	33336
29	26 and 28	15
30	nurse.tw	33531
31	26 and 30	27
32	31 not 29	21
33	from 32 keep 11,14,18,21	4
34	"religion and medicine"/	4066
35	"christianity"	2185
36	34 or 35	5700
37	ordain.tw	0
38	ordination.tw	944
39	19 and 38	23
40	19 and 36	268
41	3 or 9 or 12 or 20 or 21 or 27 or 29 or 31 or 39	145
42	40 not 41	254
43	from 42 keep 16,21-22,44,49,52,58,62,65,68	11
44	from 42 keep 86,89,94,101-102,104-105, 156,163,175,188-89	17
45	10 or 13 or 14 or 22 or 24 or 33 or 43 or 44	55

PROTOCOL FOR HUMAN INVESTIGATION COMMITTEE

Title: Survey of Episcopal clergy who are also physicians

Principle Investigator: Daniel E Hall
1056 Whitney Ave
Hamden, CT 06517
624-2620
hallde@biomed

Sponsor: Alan Mermann, chaplain
Chaplain's Office

DESCRIPTION OF STUDY

A. Purpose:

This study is designed to gather information about persons who are both physicians and clergy in the Episcopal Church. The study has two main goals. First, data will be collected to determine the total number of physician/clerics in the Episcopal Church. I hope to create a directory of these people to facilitate and encourage dialogue and mutual support. Second, the physician/clerics will be surveyed in order to characterize their patterns of professional work: What ages are these people? Do they combine their two professions, and if so how? Did they pursue both professions concurrently, or did one precede the other? What types of medicine do they practice? What types of ordained ministry do they pursue? What inspired them to be both physicians and clerics?

After collecting this and other related information, I will create a report summarizing the demographic patterns of this unique population of professionals. I hope this will be useful for my own professional development, but I will make it available to those who are either currently or aspiring to be both physicians and ordained clergy.

B Background:

To my knowledge, no similar study has ever been done. However, over the last several years, I have gathered anecdotal reports that suggest that there are many people in this country who are both physicians and clerics. I know of two people here in Connecticut, and I know of seven people in the Episcopal Diocese of Virginia alone. The population clearly exists, but it has never been characterized.

C: Specific Location of Study:

This study does not entail research in a clinical setting. Most of the correspondence will occur through the mail. However, I hope to interview people over the telephone, and if possible, I may travel to visit some people in person.

D: Probable Duration of Project:

I expect to gather most of the data by the end of August 1996. Analysis and writing will be completed by January 1997.

E: Research Plan

Phase 1: Determine the Population

I will send a letter to all the diocesan bishops of the Episcopal Church requesting the names and addresses of the clergy in their diocese who are also physicians. (Sample letter attached.) This information will be collected and combined to generate a list of all the physician/clergy in the Episcopal Church.

Phase 2: Written Survey

Once the population is defined, I will contact each physician/cleric with a written questionnaire designed to characterize the patterns of their professional lives as both physicians and clerics. This survey will be created and submitted for approval by the HIC in April 1995. It will address questions similar to those listed above in section A.

Phase 3: Interviews

After analyzing the preliminary results of the written questionnaire, I will interview a select subset of the population. I will meet with them in person or on the telephone for more in detailed conversation designed to add depth and subtlety to the characterization of the patterns of professional work of physician/clergy.

F. Economic Considerations

None.

G. Clinical Research Center Protocols Only

Not relevant

III HUMAN SUBJECTS

A. Subject Population

Subjects must be both Episcopal clergy (deacon, priest or bishop) and physicians (MD). However, not all subjects need be practicing medicine currently. Some people leave active medical practice after ordination.

B. Risks

The only significant risk is confidentiality. All subjects retain the right to refuse participation in the survey, and consent will be obtained before personal information is released or published (names, addresses, etc).

C. Consent Procedures

All personal information obtained from the survey of bishops will be held confidential. The written questionnaire to be sent to the physician/clerics will contain a consent form for participation in the survey. (Questionnaire will be submitted for approval in April 1996).

D. Protection of subjects

All personal information will be held in confidence unless explicit consent is given for its use and/or release.

E. Potential benefits

The information generated by this study may be of interest and benefit for each of the study subjects. I suspect that most physician/clergy would want a contact list of other physician/clergy, and they might appreciate a the sort of demographic summary this study will generate.

F. Risk-Benefit Ratio

The risks are minimal, and the benefit for the subjects is difficult to quantify. As long as confidentiality is maintained, the results of the study may have potential benefits for all current or future physician/clerics.

14 January, 1996

The Rt. Rev. «bishop»
The Diocese of «diocese»
«address1»
«address2»
«citystatezip»

Dear Bishop,

I am a first year medical student at Yale Medical School and a postulant in the Diocese of Connecticut. I intend to pursue a bivocational ministry as both a doctor and a priest. I hope to practice medicine as my primary form of ordained ministry, but I also hope to serve in a parish as a non-stipendiary associate.

Because the combination of these vocations is rare, I have not found many mentors who might shape the development of my vocation. For my own use, and for a research project at the medical school, I am trying to develop a list of all Episcopal clergy who also hold an MD. I am continually surprised to learn how many people are both physicians and members of the clergy. There are seven in the Diocese of Virginia!

I write to inquire about clergy in your diocese who are also physicians. If there are any such bivocational clergy in your diocese, please send me a brief letter with their names, addresses and telephone numbers. I am interested all clerics who hold an MD. They do not need to have an active medical practice. If there are no physician clergy in your diocese, please indicate this on the enclosed form and return it. All names and addresses will be held confidential.

I hope to do two things with this information. First, I will contact each physician/cleric with a brief questionnaire intended to help characterize the vocational patterns of physician clergy. Second, I hope to develop a comprehensive listing of physician clergy in the Episcopal Church. However, I will not include anyone in this list without their expressed consent. If you or anyone in your diocese would like a copy of my total list after it is formed, please indicate this on the enclosed form. Thank you for your help.

I appreciate your time and effort in responding to this inquiry. Perhaps I will have the privilege to serve in your diocese some day in the future.

Sincerely,

Daniel E Hall
1056 Whitney Ave
Hamden, CT 06517
(203) 624-2620

SURVEY OF PHYSICIAN CLERGY

Daniel Hall
1056 Whitney Ave
Hamden, CT 06517

Diocese: _____

Bishop: _____

__YES I would like a copy of the comprehensive list of physician clergy after it is completed. Please send it to the following address(es):

__NO I would not like a copy of the list.

__NO There are no clergy in this diocese who are also physicians.

__YES There are ____ (number) clergy in this diocese who are also physicians. Their names and addresses are listed below.

Name: _____
Address: _____
_____
_____
_____
Phone: _____

Name: _____
Address: _____
_____
_____
_____
Phone: _____

Name: _____
Address: _____
_____
_____
_____
Phone: _____

Name: _____
Address: _____
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Phone: _____

Name: _____
Address: _____
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Phone: _____

Name: _____
Address: _____
_____
_____
_____
Phone: _____

(Please use reverse side if more space is needed)

AMENDMENT
PROTOCOL FOR HUMAN INVESTIGATION COMMITTEE

Date: 25 March, 1996

Title: Survey of Episcopal clergy who are also physicians

Principle Investigator: Daniel E Hall
1056 Whitney Ave
Hamden, CT 06517
624-2620
hallde@biomed

Protocol #: 8646

DESCRIPTION OF AMENDMENT

I have decided to expand the scope of this study to include all denominations. My primary study population will still be physicians who are also Episcopal clergy. However, I want to get an estimate of the total number of physician clergy in the country.

Therefore, I am adding a fourth and fifth phase to the study. I will contact all US medical schools and the 100 largest US seminaries to request the names of their graduates who are both physicians and clergy. (Sample letters attached). By cross referencing these lists, I hope to get an estimate of the total population of physician clergy. I will then contact a small sample of this population with the questionnaire as described in Phase 2, Section E of my original protocol.

10 April, 1996

Director of Alumni Records
«divschool»
«address1»
«address2»
«citystate»
«zip»

Dear Friend,

I am a first year medical student at Yale Medical School and a postulant in the Episcopal Diocese of Connecticut. I intend to pursue a bivocational ministry as both a doctor and an Episcopal priest. I hope to practice medicine as my primary form of ordained ministry, but I also hope to serve in a parish as a non-stipendiary associate.

Because the combination of these vocations is rare, I have not found many mentors who might shape or support the development of my vocation. For my own use, and for a research project at the medical school, I am conducting a study to estimate the total number of physician clergy in the country. My survey of the Episcopal Church has already generated over seventy physicians who are also clergy. I am stunned by the high numbers.

I write to inquire about graduates (or students) of your seminary who are also physicians. I am interested in all physicians who are ordained or hold a Master of Divinity. If there are any such bivocational physicians among your alumni, please send me a brief letter with their names, addresses and telephone numbers. They do not need to have an active medical practice. If there are no physician clergy in your alumni, please indicate this on the enclosed form and return it. All names and addresses will be held confidential.

My primary goal is to estimate the total number of physician clergy. However, I will contact a small sample of the population with a brief questionnaire intended to help characterize the vocational patterns of physician clergy.

Thank you for your help. I appreciate your time and effort in responding to this inquiry.

Sincerely,

Daniel E Hall
1056 Whitney Ave
Hamden, CT 06517
(203) 624-2620

10 April, 1996

Office of Alumni Records
«school»
«subschool»
«address»
«address2»
«zip»

Dear Friend,

I am a first year medical student at Yale Medical School and a postulant in the Episcopal Diocese of Connecticut. I intend to pursue a bivocational ministry as both a doctor and an Episcopal priest. I hope to practice medicine as my primary form of ordained ministry, but I also hope to serve in a parish as a non-stipendiary associate.

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I write to inquire about graduates (or students) of your medical school who are also clergy. I am interested in all physicians who are ordained or hold a Master of Divinity. If there are any such bivocational physicians among your alumni, please send me a brief letter with their names, addresses and telephone numbers. They do not need to have an active medical practice. If there are no physician clergy in your alumni, please indicate this on the enclosed form and return it. All names and addresses will be held confidential.

My primary goal is to estimate the total number of physician clergy. However, I will contact a small sample of the population with a brief questionnaire intended to help characterize the vocational patterns of physician clergy.

Thank you for your help. I appreciate your time and effort in responding to this inquiry.

Sincerely,

Daniel E Hall
1056 Whitney Ave
Hamden, CT 06517
(203) 624-2620

SURVEY OF PHYSICIAN CLERGY--Medical Schools

Daniel Hall
1056 Whitney Ave
Hamden, CT 06517

Medical School: _____

__NO None of our alumni are also clergy or Masters of Divinity.

__YES There are ____ (number) alumni who are also clergy or Masters of Divinity. Their names and addresses are listed below.

Name: _____
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(Please use reverse side if more space is needed)
(Please return to Daniel Hall * 1056 Whitney Ave * Hamden, CT 06517)

SURVEY OF PHYSICIAN CLERGY--Divinity Schools

Daniel Hall
1056 Whitney Ave
Hamden, CT 06517

Divinity School: _____

__NO None of our alumni are also physicians or MDs.

__YES There are ____ (number) alumni who are also physicians or MDs. Their names and addresses are listed below.

Name: _____
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(Please return to Daniel Hall * 1056 Whitney Ave * Hamden, CT 06517)

AMENDMENT
PROTOCOL FOR HUMAN INVESTIGATION COMMITTEE

Date: 24 June, 1996

Title: Survey of Episcopal clergy who are also physicians

Principle Investigator: Daniel E Hall
1056 Whitney Ave
Hamden, CT 06517
624-2620
hallde@biomed

Protocol #: 8646

DESCRIPTION OF AMENDMENT

As described in section E of my original protocol, I am planning to contact each physician cleric with a written questionnaire designed to characterize the patterns of their professional lives. This questionnaire was not written at the time of the initial approval of this protocol. I am now submitting both the cover letter and the questionnaire for approval.

2 July, 1996

The. Rev. Dr. «name»
«address»
«city», «state» «zip»

Dear Dr. «name»,

I am a first year medical student at Yale Medical School and a postulant in the Episcopal Diocese of Connecticut. I intend to pursue a bivocational ministry as both a doctor and a priest. I hope to practice medicine as my primary form of ordained ministry, but I also hope to serve in a parish as a non-stipendiary associate.

Because this combination is rare, I have not found many mentors who might shape the development of my vocation. For my own use, and for a research project at the medical school, I am surveying Episeopal clergy who also hold an MD. I am continually surprised to learn how many people are both physicians and members of the clergy. Thus far, I have collected 75 names throughout the country.

I learned your name and address from your bishop. I have enclosed a brief questionnaire that tries to characterize patterns of bivocational ministry among physician clergy. Please take the time to complete the survey and return it to me in the enclosed self-addressed stamped envelope. All information will be held in strict confidence. I hope to do two things with the information. First, I will analyze the responses and compose a brief report that summarizes the results. This report may be published. Second, with your permission, I will include your name and address in a list of other physician clergy available on request. I hope this list might be useful in stimulating dialogue between individuals who have chosen this unique combination of vocations. Thank you for your help.

I appreciate your time and effort in responding to this inquiry. I am available to answer any questions you might have. Perhaps I will have the privilege to meet you some day in the future.

Sincerely,

Daniel E Hall
1056 Whitney Ave
Hamden, CT 06517
(203) 624-2620

AMENDMENT
PROTOCOL FOR HUMAN INVESTIGATION COMMITTEE

Date: 21 August, 1996

Title: Survey of Episcopal clergy who are also physicians

Principle Investigator: Daniel E Hall
1056 Whitney Ave
Hamden, CT 06517
624-2620
hallde@biomed

Protocol #: 8646

DESCRIPTION OF AMENDMENT

As described in section E of my original protocol, I have contacted each physician cleric with a written questionnaire designed to characterize the patterns of their professional lives. A draft of this questionnaire was approved by Susan Katz in her letter of 26 June, 1996. As instructed in that letter, I am now submitting the final draft of the questionnaire. It was mailed to 85 physician clergy on 20 July, 1996.

SURVEY OF PHYSICIAN CLERGY

This questionnaire is organized in three parts. Part I elicits background information. Part II addresses the tegration of both medicine and ordained ministry. Part III tests several assumed differences between lay physicians and ergy physicians. All information will be held confidential.

PART I--BACKGROUND INFORMATION

Name:
Address:

Telephone:

Date of MDiv:
Seminary:
CPE: (date and location)
Date of MD:
Medical School:
Residency Program and dates:

1-Which vocation came first, or did you pursue both simultaneously? (check one)
☐medicine ☐ordained ministry ☐both

2-Do you release your name and address for inclusion in a list of physician clergy? Yes / No

3-Do you wish to receive the aforementioned list along with the results of this survey? Yes / No

A-MINISTRY

Are you a priest, transitional deacon, vocational deacon, or seminarian? (circle one)

If seminarian, what order will you pursue?
Priest or Vocational Deacon (circle one)

Date(s) of ordination:
Deacon:
Priest:

In your ordained ministry, what models of Church affiliation have you pursued?
Check any that apply and circle the model that you prefer)

☐rector
☐associate
☐deacon
☐chaplain
☐missionary
☐other:_____

Briefly describe your current parish involvement. Be sure to note if any or all of your work is non-stipendiary. If seminarian, describe your expected involvement.)

B-MEDICINE

1- What is your specialty?

2-If medical student, what specialty will you pursue?

3-For how long have you practiced in this field?

4-In your career, what models of practice have you pursued?
(Check any that apply and circle the model that you prefer)

☐private
☐academic-clinical
☐academic-research
☐group
☐HMO/staff model
☐other_____

5-Briefly describe your current medical practice or research. Be sure to note if any or all of your work is non-stipendiary.
(If medical student, describe the practice you hope to pursue.)

PART II-INTEGRATION

This section seeks to characterize how you have integrated vocations in medicine and ordained ministry. The questions and the desired responses are inherently more narrative. Please take as much space as needed, attaching additional pages if desired.

Because physician clergy are an extremely diverse group, not all of these questions will apply to every person. Although the instructions occasionally suggest skipping questions, you are free to answer any question. Please answer all the questions you find relevant to your experience.

If you are a student, please respond to the best of your ability. If you have retired, please feel free to use your past experience.

1-Do you actively pursue both medicine and ordained ministry? Yes / No

If "Yes" please skip to question 5.

If "No" please answer questions 2, 3 and 4.

2-Describe how you left one vocation for the other.

☐ I left medicine to pursue ordained ministry.

☐ I left active ordained ministry to pursue medicine.

3-How, if at all, does your previous vocation inform or influence your current work?

4-Questions 5 through 21 deal specifically with the integration of medicine and ordained ministry. You are free to respond, but it may be more relevant to skip to question 22.

5-Describe how you were called to pursue both medicine and ordained ministry. How did you get to your current career situation? Could you have envisioned where you are now when you started training?

6-What is your theological foundation for pursuing these two vocations?

7-Do you integrate both vocations into a unified whole or do you keep both vocations separate? Please describe how and why you integrate or separate medicine and ordained ministry.

8-How does medicine inform your practice of ordained ministry?

9-How does ordained ministry inform your practice of medicine?

10-If you could pursue only one vocation, which would it be? Medicine or ordained ministry (circle one). Why?

11-What do you offer that is not offered by lay physicians or monovocational clergy?

12-Do you let patients know that you are ordained. If so, how? What is the reaction?

13-How do you view the patient-doctor encounter? What is appropriate? What is not appropriate? Is evangelism appropriate? Do you ever act as priest and physician to the same person? How do you manage the power issues of being both a doctor and a priest?

14-How, if at all, do you introduce God into the patient-doctor encounter? Do you have a standard way of introducing the subject of spiritual issues to the patient?

15-How do you deal with the diversity of the patient population? Does your status as "ordained" interfere with eliciting patient stories--especially regarding sensitive issues like sex, smoking, alcohol, drugs and teenagers? Is it difficult to reconcile the "non-judgmental" stance of medicine with your religious convictions?

16-How, if at all, do you minister to colleagues and staff?

17-Do your colleagues know that you are ordained? If so, what do they think? Are they generally supportive, ambivalent, discouraging?

18-Have you encountered resistance from colleagues who find the combination of medicine and ordained ministry impossible, irresponsible or even malpractice? If yes, please describe.

19-Do patients ever switch to other physicians because of your dual vocation? If yes, please describe.

20-Has your dual vocation interfered with your professional goals in either medicine or the church? If yes, please describe.

21-Given that ordained ministry and medicine are both very demanding, how do you "re-charge?"

22-How, if at all, have your two vocations influenced your theology? Specifically, what is your theology of suffering and death? How do you view the theological nature of disease?

23-How, if at all, did finances influence your vocational decisions?

24-Briefly describe your personal piety and prayer life.

25-What are the tensions between both vocations?

26-In your opinion, is it possible to integrate both vocations of ordained ministry and medicine? Why or why not? Would you recommend such an integration to someone considering a bivocational ministry, and what advice would you give?

27-Please add additional comments if desired. Thank you for your time and effort.

PART III--TESTING ASSUMPTIONS

This part of the questionnaire tests several assumptions about physicians who are also clergy. Some sensitive personal information is requested, but this information will be held in strictest confidence.

1-ETHICS

) Within your community to you take an active role in the field of biomedical ethics? Yes / No
If "yes," describe your involvement.

) Do you serve on an hospital ethics committee? Yes/No

) Are you satisfied with the current health care delivery system or do you advocate some form of change? Satisfied / Unsatisfied (circle one). Why?

) Do you believe in a constitutional right to die? Yes/No
If "yes," should physicians assist in exercising that right? Yes / No.

) Basic health care should be provided by:
(check as many as appropriate)
☐fee for service
☐ fee for service combined with physician altruism
☐a guaranteed privilege of citizenship
☐a guaranteed human right
☐other

2-MALPRACTICE

) How many times have you been sued for malpractice?
☐never
☐1
☐2-5
☐5-10
☐more than 10

) How many times have you been found negligent?
☐never
☐1
☐2-5
☐5-10
☐more than 10

) How many times have you settled out of court?
☐never
☐1
☐2-5
☐5-10
☐more than 10

d) When compared to colleagues in a similar type of medical practice, your rate of malpractice litigation is:
greater---lesser---about the same

3-COMPENSATION

a) How many hours each week do you work in your medical practice?

b) Check the range that describes your average annual income from medicine
☐less than $75,000
☐$75,000 to $150,000
☐$150,000 to $250,000
☐more than $250,000

c) When compared to colleagues in a similar type of medical practice, your compensation is:
greater---lesser---about the same

4-PATTERNS OF PRACTICE

a) What percent of your medical practice do you dedicate to charity? (i.e. What percent of your patients do you treat for free, sliding scale, or medical assistance. How much time do you volunteer at free clinics? Etc.)

b) What percent of your medical practice treats patients from underserved populations?

c) Compared with my colleagues, the time I spend talking with and getting to know my patients is:
greater---lesser---about the same

d) Compared with my colleagues, the time I spend talking with my patients about the spiritual factors of illness is:
greater---lesser---about the same

e) Have you ever been officially sponsored by a church or organization as a missionary either domestically or abroad? Yes / No
If "yes," in what capacity?
☐medicine
☐ordained ministry
☐both
If "yes," for how many years?_____

Appendix 3-Directory

The following directory includes the names, addresses and telephone numbers of all those Episcopal physician clergy who gave permission to release their personal information.

First Name	Last Name	Address	City	State	Zip	Telephone	Order
Philip	Anderson	2581 Norfolk Rd	Cleveland Hts	OH	44106	216 371 4480	2
Michael	Attas	2400 Arroyo	Waco	TX	76710	817 776 8840	3
J. Kelley	Avery	4236 Jamesborough Pl	Nashville	TN	37215	615 259 4037	1
David H.	Barnhouse	6844 Penham Place	Pittsburgh	PA	15208	412 362 3223	1
William N.	Beachy	431 W. 60th Terrace	Kansas City	MO	64113	816 523 3380	1
Harry L	Biggs	RR2 Box 554	Galena	MO	65656-9412	417 538 2505	2
Jeffrey	Boyd	10 Maplewood Rd	New Haven	CT	06515	203 573 8555	1
Anne	Brewer	27 Ring's End Rd	Darien	CT	06820	203 656 4019	1
Wiolton H.	Bunch	1700 LeRoy Ave, #14	Berkeley	CA	94209	510 845 1443	1
Charles David	Christian	6046 Warriors Trail	Vicksburg	MS	39180	601 638 9124	1
Robert	Crafts	44840 Windsor Dr	Indio	CA	92201	619 342 5091	1
M. Allen	Dawson	1375 Weisenberger Mill Rd	Midway	KY	40347	606 846 4131	2
Burton A	Dudding	1720 S Arlington Ave	Reno	NV	89509	702 323 8004	1
John	Earl	1650 5th St. NW	Hickory	NC	28601	704 328 2941	2
John P	Edwards	10518 Italia Way	Rancho Cordova	CA	95670	916 635 7980	1
Hazel D M	Farkas	22 Meadowbrook Drive	New Hartford	NY	13413	315 797 3007	2
William	Frank	4203 Maple Tree Ct	Alexandria	VA	22304	703 751 6736	1
Lynne T	Greene	1369 Vermeer Dr	Nokomis	FL	34275	941 488 0113	2
Jeffrey L.	Hamblin	332 Bleecker St H86	New York	NY	10014	212 957 0857	1
Fontaine	Hill	4227 Chanwil	Memphis	TN	38117	901 682 2769	2
Jonathan A	Holloway	South 2309 Garfield Rd	Spokane	WA	99203-3360	509 624 4836	2
Len	Howard	98-1128 Malualua St	Aiea	HI	96701	808 487 7009	2
Dina	Howell-Burke	7425 Steven Ridge Rd	Lincoln	NE	68516	402 483 5799	1
Christopher N	Jambor	5003 Dexter Ave	Ft Worth	TX	76107	817 731 1128	1
Joseph	King	4721 E 87th St South	Tulsoa	OK	74137-2830	918 494 9953	2
Warren Peter	Klam	2230 George C Marshall Drive, #1119	Falls Church	VA	22043	703 204 1740	1
Robert C	Long	913 S Abbey Crt	Springfield	MO	65809-1434	417 887 2611	2
Boyd H.	May, Jr	21311 Genito Rd	Moseley	VA	23120	804 378 7360	1
James W	Moore	18151 Dearborn	Stilwell	KS	66085	913 897 2106	2
Robert J	Moran	6675 Sedgwick Place	Brooklyn	NY	11220	718 680 1782	1
Robert F	Park	#4 Apache Lane	Kearney	NE	68847	308 237 2527	1
Raymond C	Ramage	1111 Parkins Mill Rd	Greenville	SC	29206	864 288 9061	1
Daniel H.	Riddick	680 Mayo Rd	Huntington	VT	05462	802 434 2745	1
Carlos	Sandoval-Cros	10990 SW 34th St	Miami	FL	33165	305 222 4761	1
Francis J	Shea	10 Winterberry Lane	Gibbsboro	NJ	08026	609 627 1779	1
Jon	Shematek	613 Sideling Ct	Sykesville	MD	21784	410 992 8337	2
Gabriel A	Sinisi	The School of Theology	Sewanee	TN	37383-1001	615 598 2750	3
Wharton	Sinkler	PO Box 67	Crystal Bay	MN	55323	612 476 2267	1
Virginia Francene	Stanford	4410 Gorman Dr.	Lynchburg	VA	24503	804 384 1215	1
Orille J	Stein	206 College Street	Somerset	KY	42501	606 629 2872	2
J. F. H.	Stewart	Box 1480	Ogdensburg	NY	13669	613 395 1164	1
Jared H.	Tucker	3227 Rancho La Carlota	Covina	CA	91724	818 332 1462	2
Rowena R	White	10123-B Siegen Ln	Baton roughe	LA	70810	504 767 0859	1
Alden	Whitney	167 Long Ridge Rd	Danbury	CT	06810	203 790 6123	1
Spencer Van B.	Wilking	35 Robin wood Rd	Concord	MA	01742	508 369 6064	1
Carey C	Womble	1403 Via Ronda Oeste	Tuscon	AZ	85715-4832	520 296 7388	1
Don C.	Youse, Jr.	953 W. North Ave	Pittsburgh	PA	15233	412 231 0454	1

1=priest
2=deacon
3=seminaran

Appendix 4-Web Site

One of the goals of this study was to catalyze conversation between physician clergy. To that end, the *Stole and Stethoscope* Web site is under construction to provide a forum for the exchange of ideas between ordained physicians. The Web site will have four parts. First, there will be a brief introductory and autobiographical statement by the author. Second, a copy of this study will be published. Third, a directory of physician clergy will be posted. This directory and database will be interactive, allowing new names to be added by interested parties who visit the site and meet the criteria of being physician clergy. Finally, the web site will establish a list server dedicated to fostering conversation between interested physician clergy.

At first, the directory and list server will include only those physician clergy who gave permission for the release of their personal information. However, in the near future, announcements will be mailed to the nearly 200 physician clergy known to this author. Similar letters will be mailed to all Episcopal bishops as well as interested associations. The letters will encourage other physician clergy to explore the Web site and add their names to the directory if they are willing. It is hoped that in time, the Web site will compile the most extensive directory of physician clergy of all denominations.

The Web site can be accessed by pointing a browser to:

www.members.tripod.com/~physicianclergy

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